2020 Master application for small groups (1 to 50 employees)

For coverage effective on or after January 1, 2020

1. COVERAGE EFFECTIVE DATE

Group name _____

First of (month) _____ Group number(s) _____

2. APPLICATION CHECKLIST

NEW SALES	RENEWALS
Application package must be received by the **20th of the month prior to the effective date** and include the items listed below. If incomplete materials are received, coverage may not take effect the first of the month seeking coverage, and may be delayed until the first of the following month. Please remember that meeting deadlines does not guarantee group coverage. We must still review a group's enrollment materials to make sure all company requirements and guidelines are met.	Renewal application must be received by the **10th of the month prior to the effective date.**
☐ **Completed and signed master application.** ☐ A current copy of employer's **Washington state business license.** ☐ **Completed enrollment forms** for each employee electing coverage OR **completed electronic census.** ☐ **Enrollment forms for former employees** who are eligible for COBRA. ☐ **For groups of 1 to 3 subscribers,** waiver form for each eligible employee declining coverage. ☐ **For groups of 1 to 3 subscribers,** show proof of being a business by submitting the appropriate tax documentation forms:	☐ **Review current benefits:** Medical _____ Dental _____ ☐ **Review 2020 plan choices and rate sheets.** See the 2020 plan brochure to learn about available plans. ☐ **Complete all sections of this application, sign, and return** your completed form.

Corporation	1120 (first 4 pages)
Subchapter S Corp	1120S (first 4 pages)
Partnership	1065 (first 4 pages)
Nonprofit	990
Religious organization	Tax forms not required

PLEASE NOTE: Under federal law, the term "group health plan" excludes plans that do not have employees and in which the only participant is a sole proprietor. 42 USCA §300gg-91(a); 29 CFR 2510.3-3(b) and (c). To be eligible for a small group plan, a group must have at least one common law employee.

3. REQUIRED COMPANY INFORMATION

Company name _____

Doing business as _____

Business address _____

City _____ State _____ ZIP _____ County _____

Phone _____ Fax _____ Email _____

Type of business _____

In business since _____ Federal tax ID # _____ SIC # _____

Is this business a branch office? ☐ Yes ☐ No Or subsidiary? ☐ Yes ☐ No

In which city and state is your company headquartered? City _____ State _____

Has your firm ever been covered in the past by a plan offered by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc.?

☐ Yes ☐ No If yes, under what name? _____

Date last covered _____

For new groups: Are you replacing existing group coverage?

☐ Yes ☐ No If yes, which carrier provided that coverage? _____

_____

4. REQUIRED CONTACT INFORMATION

Main contact name _____ Title _____

Company name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Email _____

Billing contact (if different from above)

Name _____ Title _____

Company name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Email _____

5. REQUIRED ENROLLMENT INFORMATION

1. A small group is a business with 1 to 50 employees, as defined under applicable state and federal law. (To be eligible for a small group plan a group must have at least one common law employee.) How many total employees, part-time and full-time combined, does your company have? _____
   (Please include out-of-state and worldwide employees for all parent, subsidiary, and sibling companies in this total.)

2. COBRA: Did you employ 20 or more full-time equivalent employees at least 50 percent of the year in the past calendar year? ☐ Yes ☐ No
   If yes, your company is required by federal regulations to offer COBRA benefits to terminated employees. If you have any questions regarding COBRA applicability or eligibility, please seek the advice of independent legal counsel.

   2a. Does your company have any terminated employees on COBRA benefits now? ☐ Yes ☐ No

3. TEFRA: Did you employ 20 or more employees each working day during each of the 20 or more calendar weeks in the current or preceding calendar year? ☐ Yes ☐ No If yes, this law generally applies to you.

4. How many hours per week must employees work to be eligible for benefits?_____

5. How many employees meet the above requirement?_____

6. Of these employees: How many are enrolling? _____

   How many are waiving coverage? _____

7. Employees will be eligible for benefits upon **(select one)**:

   ☐ First of the month following or coincident with date of hire

   ☐ Date of hire

   ☐ First of the month following ☐ date of hire ☐ 30 days ☐ 60 days

   ☐ 90 days from date of hire

   ☐ Other – No longer than 90 days from date that employee is otherwise eligible to enroll. Any orientation period required for an employee to be eligible to enroll may not exceed one calendar month. Please specify: _____

   7a. Waive probationary period during open enrollment? ☐ Yes ☐ No

8. Rehire policy:

   The company will waive the waiting period if employee is rehired **(select one)**:

   ☐ None – Rehired employees must satisfy probationary period

   ☐ Within 30 days of termination

   ☐ Within 60 days of termination

   ☐ Within 90 days of termination

   ☐ Other: _____

9. Employee transfers from part-time to full-time **(select one)**:

   ☐ Probationary period begins upon date employee transfers to full-time.

   ☐ Coverage begins on the first of the month following transfer to full-time.

10. Does your company include non–state-registered domestic partners of employees as eligible dependents?

    ☐ Yes ☐ No

    Note: State-registered domestic partners will be treated as spouses as required by Washington state law.

6. SELECT BENEFITS

Mix and match plans across our 3 network options to find the best fit for your business:

- **Groups with 1 to 5 employees** may offer up to 3 plans.
- **Groups with 6 to 50 employees** may offer any number of plans. (Offering up to 3 plans may be ideal for groups of this size.)
- **For a plan to be available to new group members during the contract year,** a group must have at least 1 employee enrolled in the plan when offered at the time of a new group setup or at renewal.
- **Elect PPO plans** are available only in King, Kitsap, Pierce, Snohomish, and Thurston counties.

Kaiser Foundation Health Plan of Washington
Core provider network

☐ Bronze HSA	☐ Gold
☐ Silver HSA	☐ Core VisitsPlus Gold LX[3]
☐ Silver	☐ Core VisitsPlus Gold LX[3]-EO[1]
☐ Core VisitsPlus Silver LX[3]	☐ Core VisitsPlus Gold HD[2] LX[3]
☐ Core VisitsPlus Silver LX[3]-EO[1]	☐ Core VisitsPlus Platinum LX[3]

[1] EO – Employee-only contract [2] HD – High deductible [3] LX – Lab and X-ray

Kaiser Foundation Health Plan of Washington Options, Inc.
Access PPO provider network

☐ Access PPO Bronze HSA	☐ Access PPO VisitsPlus Gold LX[3]
☐ Access PPO Silver HSA	☐ Access PPO VisitsPlus Gold HD[2] LX[3]
☐ Access PPO VisitsPlus Silver LD[4] LX[3]	☐ Access PPO VisitsPlus Platinum LX[3]
☐ Access PPO VisitsPlus Silver LX[3]	
☐ Access PPO VisitsPlus Silver LX[3]-EO[1]	

[1] EO – Employee-only contract [2] HD – High deductible [3] LX – Lab and X-ray [4] LD – Low deductible

Kaiser Foundation Health Plan of Washington Options, Inc.
Elect PPO provider network – available only in King, Kitsap, Pierce, Snohomish, and Thurston counties.

☐ Elect PPO VisitsPlus Silver LX[3]	☐ Elect PPO VisitsPlus Platinum LX[3]
☐ Elect PPO VisitsPlus Gold LX[3]	

[3] LX – Lab and X-ray

6. SELECT BENEFITS (continued)

Dental plan (must select one)

Please select one of the optional adult/family dental plans for your employees and their dependents **OR** choose the mandated pediatric-only dental coverage. Dependents include spouse/domestic partners and dependent children 25 and younger.

☐ Small Group Standard adult/family dental plan ($1,500 annual maximum)

☐ Small Group Basic adult/family dental plan ($1,000 annual maximum)

☐ Pediatric-only dental plan (This is required and must be added if no adult/family dental plan is chosen.) The Affordable Care Act mandates pediatric dental coverage for anyone 18 and younger enrolled in the medical plan.

Note: Dental premiums for employees or applicable dependent enrollees 18 and younger will be assessed and billed separately from the medical premiums.

Coverage provided by Delta Dental of Washington, 400 Fairview Ave. N., Suite 800, Seattle, WA 98109-5371.

7. RATING STRUCTURE

Select one:

☐ **Age-banded rates** (or "list bill"). All individuals are charged based on the age band determined by their age at plan effective date. Age bands are 0 to 14, then by year from 15 to 63, and 64 or older. The 3 oldest children 0 to 20 in each family are charged.

☐ **Composite rates** comprise 2 rates. One rate – for all enrollees 21 and older – is determined by their combined average age-banded rate. Another rate – for all enrollees 20 and younger – is determined by their combined average age-banded rate. The 3 oldest children 0 to 20 in each family are charged.

Premium contribution

The employer agrees to make the following contribution toward the employee and dependent coverage:

Employers must contribute a minimum of 50% of the employee premium to qualify for group coverage. **Contribution applies to the base plan if eligible and offering more than one plan.**

Employee $ or % _____ **Dependents $ or %** _____
(Minimum 50%) (None required)

8. ACKNOWLEDGEMENTS AND CERTIFICATION

Authorized representative certification

I certify that the information on this application is complete and accurate. I understand that if false information has been submitted, Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., will have the right to cancel the contract to the extent allowable under applicable federal and state law. Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., reserve the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses, or other damages. It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

Full legal name _____ Title _____

Authorized representative's signature _____ Date _____

Full legal name _____ Title _____

Authorized representative's signature _____ Date _____

9. APPOINTMENT OF PRODUCER OF RECORD

Please complete this section if you have a Producer of Record representing your company.

I hereby appoint _____ (Producer)

with _____ (Agency),

as a Producer of Record, effective _____, for purposes of arranging and servicing health care coverage with Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., for the firm's employees and dependents.

This appointment rescinds all previous appointments and continues in effect until termination by either party in writing. Producer may make requests concerning rates, benefits, eligibility requirements, and other matters relating to our company's coverage. The firm understands that commissions due to the Producer for services provided pursuant to the appointment are governed by an agreement between the Producer and the health plan.

If you are a Producer who completed this application on behalf of a client, please indicate by signing here.

Producer signature _____ Phone number _____

Name of Producer (please print) _____ Fax number _____

Address _____ Email _____

SS or tax ID number _____ License number _____

10. SEND THE MATERIALS TO:

Western Washington

Kaiser Foundation Health Plan of Washington
Small Group
P.O. Box 35002
Seattle, WA 98124-3402

206-630-4140 or 1-800-542-6312
Fax: 206-877-0654
Email: smallbusinessgroup@kp.org

kp.org/wa/smallgroup

Eastern Washington

Kaiser Foundation Health Plan of Washington
Small Group
5615 W. Sunset Highway
Spokane, WA 99224-9454

509-241-7471 or 1-800-497-2210
Fax: 509-459-1080
Email: smallbusinessgroup@kp.org

kp.org/wa/smallgroup

Dependent children are eligible for coverage through the age of 25 regardless of marital status, student status, or eligibility for coverage under another plan. Dependents are not required to reside with the subscriber. Dependents are not required to be dependent upon the subscriber for support. Eligibility for medical assistance is not considered when determining eligibility for coverage or making payments. If children of the primary insured are covered, children of a domestic partner are eligible for coverage on the same basis. All medical plans offered and underwritten by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., at 601 Union St., Suite 3100, Seattle, WA 98101.