Kaiser Foundation Health Plan of Georgia, Inc.

Kaiser Permanente Insurance Company

KAISER PERMANENTE®

SMALL GROUP EMPLOYER APPLICATION

(FOR GROUPS WITH 2-50 ELIGIBLE FULL-TIME EMPLOYEES)

This form must be completed and signed by the employer. This application is subject to review and approval by the Health Plan and/or KPIC, as applicable. Please Note: Statements made in the application form are deemed representations and not warranties.

Section 1. EMPLOYER INFORMATION

Firm's Legal Name

DBA (Doing Business As), if applicable

Address of Location Applying

City State ZIP

County SIC Code

Billing Address, if different from the above

Address

City State ZIP

Headquarter Address, if applicable

Address

City State ZIP

Does your organization have an address specifically for the receipt of all Coordination of Benefits issues and questions?
❑ Yes ❑ No

If yes, please provide that address below:

Address City State ZIP

First & Last Name of Key Contact Person

Telephone Number of Key Contact Person

E-mail Address of Key Contact Person

EIN/TIN (Employer Identification Number/Tax Identification Number)

Are all of the Kaiser Permanente subscribers in your group associated with the EIN/TIN above? ❑ Yes ❑ No

If you do not have a federal EIN/TIN, are you a foreign-owned organization? ❑ Yes ❑ No

Describe nature of business, including primary services and products.

❑ Corporation ❑ Partnership ❑ Proprietorship
Number of years in business _____

Type of Group Plan Sponsor (check one):
❑ Employer ❑ Labor Organization
❑ Trustees of a fund established by one or more employers labor organizations.

Type of Organization (check all that apply):
❑ State Government ❑ Publicly traded corporation
❑ Local Government ❑ Privately held corporation
❑ Church ❑ Non-profit ❑ Other

Section 2. PRIOR COVERAGE

Is this application made to replace any existing group insurance? ❑ Yes ❑ No

Name of existing or prior group insurance carrier and policy number:

_____

Has group had prior coverage within last 12 months?
❑ Yes ❑ No
Date prior coverage terminated (mm/dd/yy) ____ ____ ____

A copy of your most recent billing statement must be submitted with this application.

Section 3. ELIGIBILITY

Effective date desired (mm/dd/yy)_____/_____/_____
(In no instance may coverage be backdated.)

Present eligible, full-time employees to be insured (check one):

❑ Immediately, subject to approval by Health Plan and/or KPIC, as applicable.

❑ The first of the month following_____days from the first day of work (waiting period).

Future eligible, full-time employees will be eligible to be insured the first day of the month following _____days from the first day of work (minimum 30 days). Employees who are eligible to be insured at the time of employer's original enrollment and who are approved by Health Plan and/or KPIC, as applicable, will be insured on the effective date specified above in this agreement, if approved by the Health Plan and/or KPIC, as applicable. All other full-time employees may be eligible to be insured the first of the month after the waiting period expires. The effective date will be the first of the month following receipt and approval by Health Plan and/or KPIC, as applicable of signed and properly completed *Employee Enrollment Application* and such additional information as may be required. All employees and dependents who are not original enrollees are subject to the requirements and conditions specified in the administrative information which will be sent to the employer upon approval and issuance of coverage by Health Plan and/or KPIC, as applicable.

Health Plan and/or KPIC, as applicable, reserves the right to require such additional information including medical records and questionnaires that it deems necessary before approving and issuing any coverage for any present or future employee or dependents.

Group size — Total number of full and/or part-time employees (check one): ❑ 1-19 full and/or part-time employees
❑ 20-50 full and/or part-time employees for 20 or more weeks of either the current or the prior year

Number of full-time employees applying for coverage: _____

Total number of ineligible, part-time employees: _____

Number of eligible, full-time employees waiving coverage: _____

Has anyone in your group currently exercised their rights under COBRA, is currently totally disabled, on disability retirement, or extended sick leave?
❑ Yes ❑ No

_____
Name

Is your organization a Taft-Hartley, Hours Bank, or multi-employer organization?
❑ Yes ❑ No

Does your company have separate locations, affiliates, or subsidiaries?
❑ Yes ❑ No Please list them below:

_____
Name

_____
Location

Number of employees: _____

Number of employees covered on this plan: _____

If there are additional addresses, please list them on a separate sheet.

Section 4. AGREEMENTS

The undersigned employer hereby certifies that the firm indicated employs _____ full-time (equivalent to 30 hours per week or more) employees and that no part-time employees have been included for coverage. The employer agrees to contribute toward the premium cost the following percentages: _____ % for employees, _____ % for dependents. The employer must contribute a minimum 50% toward the employee portion of monthly premium. The employer understands the licensed broker, if any, who solicited this application was acting as an independent contractor and not as a broker of the Health Plan and/or KPIC, as applicable. Furthermore, the broker who solicited this agreement or upon whose explanation of coverage and benefits employer relied is in fact employer's broker for purposes of this agreement. It is understood that as an independent contractor and as employer's broker that person has no right to bind this coverage or to alter terms or conditions of any policies or any enrollment applications or to waive any requirements of Health Plan and/or KPIC, as applicable, or to adjust any claims for benefits under this insurance for which employer is applying. The employer acknowledges and agrees that coverage under any policy will only be as and to the extent provided, and it is employer's duty and responsibility to explain this to each person for whom coverage is sought. Employer has reviewed the benefits and limitations of coverage in the benefits summary and has explained such benefits and limitations to each person for whom coverage is sought. It is also acknowledged and agreed that coverage will begin only: (1) if this agreement is approved by Health Plan and/or KPIC, as applicable, (2) if written notice of approval is received by employer, and (3) upon the effective date inserted by Health Plan and/or KPIC, as applicable in the approval form and in the written notice of approval to employer. The absence of written approval will not imply approval.

Employer may cancel this agreement at any time upon 30 days prior written notice to Health Plan and/or KPIC, as applicable. For the duration of coverage, employer agrees to pay premiums on a monthly basis or at such other frequency as agreed upon by Health Plan and/or KPIC, as applicable. If Health Plan and/or KPIC, as applicable, does not receive payment in full within the time allowed, this will automatically constitute withdrawal and cancellation of all coverage. The effective date of coverage termination will be 12:01 a.m. of the first day of the billing period for which the pre-

mium was not paid when due if: (1) coverage is terminated because of nonpayment of premium in full; or (2) employer has not given prior written notice of cancellation. Coverage for the participating employees and their dependents will be continuous unless (1) the employee terminates employment; (2) the employee or dependent ceases to be eligible; or (3) requirements of this agreement are not maintained by the participating parties hereunder, including employer and employees. Employer agrees that the terms and benefits of the policies may be amended, modified, or changed at any time upon 60 days prior notice to employer. The employer is establishing this plan to provide medical and other benefits to its eligible employees and dependents.

Employer acknowledges that this plan constitutes an employee welfare benefit plan and agrees, as "sponsor," to fully comply with the applicable provisions and requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Employer designates Health Plan and/or KPIC, as applicable, as the named fiduciary for claims and appeals arising under the Group Agreement and/or Group Policy, as applicable. Neither Health Plan nor KPIC is the administrator of employer's employee benefit plan as that term is defined under ERISA. This provision only applies to an employer who sponsors an employee welfare benefit plan covered by ERISA, and where Health Plan's and/or KPIC's group health coverage is a component of that employee welfare benefit plan.

Section 5. BENEFITS — Check desired box(es)

HMO PLANS

- ❑ KP/0/15/S1
- ❑ KP/0/25/S1
- ❑ KP/500/20/S1
- ❑ KP/1000/20/S1
- ❑ KP/1500/20/S1
- ❑ KP/2000/20/S1
- ❑ KP/2500/20/S1
- ❑ KP/3000/40/S1
- ❑ KP/4000/40/S1
- ❑ KP/5000/40/S1
- ❑ KP/7500/40/S1

MULTI-CHOICE PLANS

- ❑ POS/0/15/S1
- ❑ POS/500/20/S1
- ❑ POS/1000/20/S1
- ❑ POS/1500/20/S1
- ❑ POS/2000/20/S1
- ❑ POS/2500/20/S1
- ❑ POS/3000/40/S1
- ❑ POS/5000/40/S1

Multi-choice plans are paired with a corresponding HMO. Please contact your broker to determine which HMO Plan is available to be matched with the Multi-Choice plan you have chosen.

HSA QUALIFIED HMO PLANS

- ❑ Plan A
- ❑ Plan B
- ❑ Plan C
- ❑ Plan D
- ❑ Plan E

OUT-OF-AREA PPO PLANS

- ❑ Plan A
- ❑ Plan B
- ❑ Plan C
- ❑ Plan D
- ❑ Plan E

HMO plans (including Deductible Plans), and the Select provider benefit level of the Multi-Choice plans are provided by Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan). The PPO provider and Non-Participating Provider benefit levels of the Multi-Choice plans and Out-of-Area PPO plans are underwritten by Kaiser Permanente Insurance Company (KPIC).

Section 6. REQUEST FOR COVERAGE

We hereby apply for the group benefits set forth in the benefit summary brochure. We understand that the following conditions must be met before insurance becomes effective, and must continue to be met. To be eligible:

1) Employees must be full-time, working 30 or more hours per week and earning compensation equal to a minimum of the federal minimum wage.

2) This agreement must be accepted and approved in writing by Health Plan and/or KPIC, as applicable.

3) The following enrollment percentages must be met and continuously maintained:

   - Firms with two or three eligible employees must maintain 100% participation for health coverage of all eligible employees.
   - Firms with four through 50 eligible employees must maintain 75% participation for health coverage of all eligible employees.

Any employees who are covered for health care under Champus/Champva, Medicare, or their spouse's group coverage may waive health coverage. The participation schedule would apply to the remaining eligible employees. The employer will (1) maintain the records necessary to the administration of the agreement; (2) report additions, changes, terminations, and other information necessary to the administration of the agreement to Health Plan and/or KPIC, as applicable, within 30 days after the effective date of such additions, changes, and terminations; (3) agree that if employer does not notify Health Plan and/or KPIC, as applicable, of any insured ineligibility or termination within 30 days, shall forfeit any premium refund/credit that would otherwise have been due; (4) make all such records, including payroll records, tax return, and personnel files and other documentation as determined by the Health Plan and/or KPIC, as applicable, available upon request to the Health Plan and/or KPIC, as applicable, or its authorized representative; (5) pay all premiums in accordance with the terms of this agreement; and (6) notify all employees of any termination or rescission of coverage which affects them and refund the appropriate premium.

Section 7. SIGNATURE

All statements provided in this agreement are true, correct, complete, and within our personal knowledge. We have read and understood this agreement. We understand and agree that this agreement will become binding between Health Plan and/or KPIC, as applicable, and us only upon acceptance by Health Plan and/or KPIC, as applicable. The absence of written approval will not imply approval. Any intentional material misstatement or incomplete statement of fact will be deemed a misrepresentation and will result in termination of all coverage with respect to us, our participating employees, and their dependents without liability to the insurer.

Signed this_____ day of _____

City_____ State_____

_____
By (Signature of Authorized Company Officer)

_____
Title

Premium deposit collected: $ _____

_____
Authentication Code for CAS *(Any 4 to 10 letters and/or numbers)*

_____
Name of Employer

_____
Witness (Signature of Licensed Broker)

_____
Please Print Broker Name

_____
Broker Designation: I hereby designate

_____ as the broker of record.
(Broker Name)

_____
Signature of Authorized Company Officer Date

For Health Plan and/or KPIC, as applicable, Use Only:

_____
Approved by

_____
Date (mm/dd/yy) Effective Date (mm/dd/yy)

Section 8. WRITING BROKER INFORMATION

❑ Please check box if this is to replace address currently on file.

_____
Writing Broker's Name

_____
Street Address

_____
Area Code Telephone Number

_____
Fax

_____
Mailing Address

_____
City State ZIP

_____
Social Security Number or Tax I.D. Number

_____
Broker's E-mail Address

_____
Broker's License: State License Number

Broker's Statement:

To the best of my knowledge and belief, all medical history, employment, and other information supplied in the group enrollment application is true and complete. I acknowledge that I represent and am acting on behalf of my client and not for, or as, an employee of Kaiser Foundation Health Plan or KPIC. I have explained the benefits and limitations of coverage and advised my client not to terminate any existing coverage until receiving written notice that the coverage being applied for under the new program has been approved. I understand that I have no right to bind this coverage, or to alter terms of the insurance concerning incomplete or additional underwriting information.

_____
By (Writing Broker's Signature)

_____
Date Month/Day/Year

General Agent Stamp