

New Group Enrollment Provisions and Application

Questions?
Call... 1·800·789·4661

Enrollment Provisions

As an employer interested in offering Kaiser Permanente coverage, you should be aware of the following provisions:

Eligibility

- Employees and their family dependents (spouse, unmarried children to age 19, and students to age 24) are eligible for coverage if they live within our Service Area.

Annual Open Enrollment

- Once a year, employees must be given the opportunity to change plans or add dependents not previously enrolled.
- Employees and/or dependents who do not enroll when first eligible must wait until the annual open enrollment period to enroll.

Subscriber Minimum

- Your company qualifies for our group coverage when you offer health care benefits to at least 2 to 50 employees and /or owners, working 20 hours or more per week. Eligibility is defined as those living in the Service Area as defined below.

California Enrollment Guidelines: Minimum of 1 enrolled, with at least 70% of eligible employees covered by any group health plan (i.e. through their employer or their spouse's).

Employer's Contribution and Payroll Deduction

- Your contribution must be at least 50% of the Kaiser Permanente rate for single subscribers. Any part of the cost not paid by your company must be collected from the employees through payroll deductions.

Full-Month Coverage

- Kaiser Permanente membership begins on the first day of the month following the waiting period that you specify and continues through the end of the termination month.

Our Service Area ZIP Codes

All new membership in Kaiser Permanente is limited to those individuals who reside within the ZIP codes listed below:

Northern California

93230-32	93673	94200-99	94922-31	95044	95296-98	95390	95465	95680-83
93242	93675	94300-99	94933	95046	95304	95397	95471-73	95686-88
93601-02	93700-99	94400-99	94937-42	95050-57	95307	95401-09	95476	95690-98
93604	93800-99	94501-02	94945-57	95070-71	95313	95416	95486-87	95703
93606-07	94002-03	94506-31	94960	95101-99	95316	95419	95492	95722
93609	94005	94533	94963-66	95201-13	95319-20	95421	95602-05	95736
93611-14	94010-12	94535-53	94970-79	95215	95323	95425	95607-26	95741-43
93616	94014-31	94555-66	94998-99	95219-20	95326	95430-31	95628	95746-47
93618	94035	94567*	95002	95227	95328-30	95433	95630	95758-59
93623-27	94037-45	94568-83	95008-09	95230-31	95336-37	95436	95632-35	95762-63
93630-31	94059-67	94585-92	95011	95234	95350-58	95439	95638-41	95765
93637-39	94070-71	94595-99	95013-16	95236-37	95360-61	95441-42	95645	95776
93643-46	94074	94601-99	95020*	95240-42	95363	95444	95648	95798-99
93648-54	94080	94700-99	95021	95253	95366-68	95446	95650-52	95800-99
93656-57	94083	94801-50	95026	95258	95376	95448	95655	95903
93660	94086-90	94901-04	95030-33	95267	95378	95450	95658-64	95961
93662	94096-99	94911-15	95035-38	95269	95380-82	95452	95667-74	
93666-69	94100-99	94920	95042	95290	95385-87	95462	95676-78	

Southern California

90000-899	92018-27	92100-99	92284-86**	92369	92581-87	93099	93280	93560-61
(except 90704)	92029-30	92201-03**	92292**	92371-78	92595-96	93203	93285	93563
91000-899	92033	92210-11**	92305	92382	92599	93205-06	93287	93581
91901-03	92037-40	92220	92307-08	92385-86	92600-899	93215-16	93301-09	93584
91908-17	92046	92223	92313-18	92391-94	93001-09**	93220	93311-13	93586
91921	92049	92230**	92320-22	92397	93010-12	93222	93380-90	93590-91
91931-33	92051-58	92234-36**	92324-26	92399	93015-16	93224-26	93501-02	93599
91935	92064-65	92240-41**	92329	92400-99	93020-21	93238	93504-05	
91941-47	92067-69	92252-56**	92333-37	92500-32	93022**	93240-41	93510	
91950-51	92071-72	92258**	92339-41	92543-46	93030-35**	93243	93518-19	
91962-63	92074-75	92260-64**	92345-46	92548	93040	93250-52	93531-32	
91976-80	92078-79	92268**	92350	92551-57	93041-44**	93261	93534-36	
91990-91	92082-85	92270**	92352	92562-64	93060-61**	93263	93539	
92007-09	92090-93	92274-78**	92354	92567	93062-66	93268	93543-44	
92014	92096	92282**	92357-59	92570-72	93093	93276	93550-53	

* The communities which lie in the above ZIP codes are not in the Service Area: Knoxville, Bells Station.

** Subscribers residing in Coachella Valley (greater Palm Springs area) and Western Ventura County zip codes are required to select a primary care Plan Physician (Affiliated Physician) for themselves and each covered dependent. Members will be contacted after enrollment regarding Plan Physician (Affiliated Physician) selection.

New Group Application



Please answer *all* questions.

This application for Kaiser Foundation Health Plan benefits is intended for the business(es) below (attach additional sheets if necessary).

Effective date _____
 Rating (circle one) Age Banded Composite

Small Business Advantage (please select and circle one plan)

	Southern California				Northern California			
Traditional Plan for Small Business	Plan 2	Plan 3	Plan 4	Plan 5	Plan B	Plan C	Plan D	Plan E
Added Choice for Small Business*	Plan				Plan			

*Jointly offered by Kaiser Foundation Health Plan, Inc. and Kaiser Permanente Insurance Company.

Check here to select the optional Delta Dental coverage. Please provide selected plan type _____

Business name _____

Address (in California) _____

City _____ State _____ ZIP _____

Phone (_____) _____ Fax number (_____) _____

Type of business _____ In business since _____

Check here if you have previously had group insurance through Kaiser Permanente.
 (Please provide your previous Kaiser Permanente Group Number _____.)

Check here if you currently have coverage through Pac Advantage, formerly known as the Health Insurance Plan of California (HIPC).

Principal Owners

- Name _____ Title _____ Social Security Number _____
- Name _____ Title _____ Social Security Number _____

Including partners, proprietors, and employees of affiliates who are entitled to file a joint return, the company currently employs, in all locations, _____ individuals. Of those, _____ would be in a class eligible for coverage under Health Plan.

How long must a new hire be employed before being offered health care benefits for the first of the month effective date following the waiting period? (check one) 30 days 60 days 90 days 6 mos. 1 yr. Date of hire
 (Employee will be effective on the first of the month following this waiting period.)

Billing statements to be mailed to (person/title) Mr. Ms. _____

Address _____ City _____ State _____ ZIP _____

Contract to be mailed to (person/title) Mr. Ms. _____

Address _____ City _____ State _____ ZIP _____

Please complete, sign, and date below.

As company principal/corporate officer, having authority to contract with Kaiser Foundation Health Plan, Inc., I agree that my company will contribute _____% of the rate for each employee for plan _____, that our prepaid monthly dues will be submitted by the 30th of each month, prior to the month of coverage, and that my company will abide by the contract provisions. Except for Small Claims Court cases, any claim asserted for alleged violation of any duty arising out of or relating to the Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to the Agreement, irrespective of legal theory, must be decided by binding arbitration under California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. I understand that Members enrolled under the Agreement thus give up their right to a jury trial, and instead accept the use of binding arbitration as specified in Section 8 of the Agreement. I consent that any person may give information to Kaiser Foundation Health Plan, Inc. concerning the credit history of the company's principal owners.

Employer Signature _____ Title _____ Date _____

I authorize the following individual to act as Broker of Record for Kaiser Foundation Health Plan, Inc.

Broker name _____

Firm name _____

Broker address _____

City _____ State _____ ZIP _____

Phone (_____) _____ Fax number (_____) _____

Cal. L&D Lic. number _____ Expiration date _____

Employer Signature _____ Title _____ Date _____

Note: Submission of this application does not guarantee that coverage will be offered. Kaiser Foundation Health Plan reserves the right to accept or decline any application.