

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.