

Small Business Group Application

Group # _____

Please complete all information. We cannot process incomplete applications.



Group name (legal business name) _____ Phone _____

DBA/Alternate name _____ Fax _____

Street address _____ City _____ County _____ State _____ Zip code _____

Mailing address, if different than above _____ City _____ State _____ Zip code _____

Type of business _____ SIC Code _____ In business since _____ E-mail address _____

Date you would like your contract to begin _____

Business Structure

Corporation Partnership Ltd. Partnership Proprietorship Self-employed Group of One

If corporation: state in which you are incorporated _____ Date incorporated _____

Branch Subsidiary Parent company name _____

Street address _____ City _____ State _____ Zip code _____ Phone _____

Principal Owners or Stockholders

If non-profit, please check box and provide information for key contact person(s).

Full name _____ Title _____

Street address _____ City _____ State _____ Zip code _____ Phone _____

Full name _____ Title _____

Street address _____ City _____ State _____ Zip code _____ Phone _____

Broker Information, if applicable

Steve Roper _____ 303 721-1145 _____ 303 721-1085 _____
Broker Phone Fax

Roper Insurance _____ steve@roperinsurance.com _____
Firm E-mail address

116 Inverness Dr. E. #265 _____ Englewood Co _____ 80112 _____
Mailing address City State Zip code

Plan Information

Indicate which plan(s) you want to offer: (Please check off and print plan name and/or number as appropriate.)

- | | |
|---|---|
| <input type="checkbox"/> Classic _____ (_____) | <input type="checkbox"/> Chamber Plan ² _____ |
| <input type="checkbox"/> Classic _____ (_____) | <input type="checkbox"/> Deductible/Coinsurance _____ |
| <input type="checkbox"/> Basic | <input type="checkbox"/> Deductible/Coinsurance _____ |
| <input type="checkbox"/> Standard | <input type="checkbox"/> MultiChoice SM POS ³ _____ |
| <input type="checkbox"/> Plus _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> HSA-Qualified Deductible plans _____ | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> Out-of-Area PPO ^{3, 4} _____ |

Supplemental benefits: None

- Dental Plan _____ (print plan name) Optical
- Chiropractic¹ Acupuncture¹ Basic Plan Option⁵

¹ Acupuncture and/or chiropractic not available with HSA-Qualified plans. ³ KPIC Colorado Purchaser Application must be completed

² Available only in the Colorado Springs service area.

⁴ No supplements are available with Out-of-Area PPO plans.

⁵ This no-cost option will be added to the Basic Plan coverage unless you contact us to decline:

Denver-based companies call 303-338-3700 — Southern Colorado-based companies call 719-867-2100.

Same Gender Domestic Partner Coverage

Do you wish to select Same Gender Domestic Partner Coverage? Yes No

Medicare

Effective January 1, 2006, Medicare Part D prescription drug coverage is available to Medicare eligible retirees/employees. Small Business Group employers have two options for Medicare Part D pharmacy benefits. Employers may elect to enroll Medicare eligible retirees/employees in Medicare Part D pharmacy through Kaiser Permanente, or apply for the Group Retiree Drug Subsidy from the Centers of Medicare and Medicaid Services (CMS).

- Choose one: elect to enroll our Medicare eligible retiree/employees in Medicare Part D.
 elect to apply for the Group Retiree Drug Subsidy for our Medicare eligible retiree/employees.
 our group does not currently have any Medicare eligible retiree/employees.

Eligibility Requirements

Group defined eligibility: All employees working at least 24 hours Other _____

New employees will become eligible the first day of the month following:

- Date of hire 30 days 60 days 90 days Other _____

Total number of employees enrolling in Kaiser Permanente at this time _____ Total number of retirees _____

Total number of eligible employees waiving with credible coverage⁸ _____

⁸ Colorado Division of Insurance requires signed waivers for: 1) all eligible waiving employees, and 2) enrolling employees' spouses/dependents not enrolling with Kaiser Permanente at this time.

Employee Rate Information

By Colorado State regulation, monthly rates are based on the ages and family size (status) of your employees who enroll in Kaiser Permanente. All small groups are offered the same age-banded rates. If your group has 10 or more eligible employees, we can provide composite rates based on a group's average age and family status of enrolling employees. This rate applies to each enrollee, according to family status, regardless of age.

If your group has 10 or more eligible employees, please indicate which rate structure your group wants for the 12-month contract:

- Composite rates⁷ Age-banded rates

⁷ Composite rates will also be generated for supplemental benefits.

Billing statements to be mailed to: Person/Title _____ Phone _____ Fax _____

Mailing address _____ City _____ State _____ Zip code _____

Contract to be mailed to: Person/Title _____

Mailing address _____ City _____ State _____ Zip code _____

To comply with Colorado Division of Insurance reporting requirements, provide the following information

Total number of employees working at least 24 hours: within Colorado _____ outside Colorado _____

Options available:

- Fixed dollar contribution must be at least \$125 per month per subscriber \$ _____
- Percent of contribution must be at least 50 percent of the lowest plan offered per month per subscriber _____%

Previous carrier _____ Plan# _____ Renewal date _____ or

Check here if your company has been without coverage three months or longer.

Yes No Is your company domiciled in Colorado?

Yes No Was this health benefit plan marketed through your place of business?

Yes No Are you treating this health benefit plan as part of a plan or program under Section 162, Section 125 or Section 106 of the United States Revenue Code?

Section 162: Employer purchased the insurance for the employee and pays the premium; employer deducts the premium as compensation to the employee and is taxable income to the employee.

Section 125: Cafeteria Plan or Flex Plan employees can choose from among two or more benefits

Section 106: Employer contributed to the employee's plan and employer contribution is excluded from the employee's gross pay.

Yes No Does your existing carrier currently cover any former employees or dependents under continuation of benefits (COBRA) in accordance with state or federal regulations?

As company principal/corporate officer, having authority to contract with Kaiser Permanente, I agree that our prepaid monthly dues will be submitted by the last working day of each month, prior to the month of coverage, and I will abide by the contract provisions. I consent that any person may give information to Kaiser Permanente concerning the principal owners' and stockholders' credit history.

Please print name (Company representative) _____ Signature _____

Title _____ Date _____

Important: Have you included paperwork indicating your company is a bona fide business?

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

COLORADO PURCHASER APPLICATION



Application is hereby made for group coverage based upon the following statements and representations: This group qualifies as a small group under applicable Colorado law: Yes No

SECTION 1 – PURCHASER’S INFORMATION

Purchaser’s legal business name: _____ Group ID# _____
(To be assigned by KFHP)

Business address: _____
Street City State Zip

Mailing address: _____
 (If different) Street City State Zip

Executive contact person: _____

Title: _____ Phone: (_____) _____ Fax: (_____) _____

Billing contact person: _____

Title: _____ Phone: (_____) _____ Fax: (_____) _____

Federal Tax ID number: _____ Primary SIC Code: _____

Nature of business: _____ Years in business: _____

	KFHP service area	Outside service area*	TOTAL
A. Total number of permanent employees eligible to participate in a purchaser-sponsored health plan	_____	_____	_____
B. Total number of employees requesting KPIC group health coverage:	_____	_____	_____
C. Total number of eligible employees enrolled in a purchaser-sponsored group health plan(s):	_____	_____	_____

* Outside service area refers to employees residing outside of Kaiser Foundation Health Plan’s (KFHP’s) service area.

SECTION 2 – REQUESTED EFFECTIVE DATE

If requesting an anniversary date other than the usual 12-month period from the effective date, please indicate the reason for request under Section 7. Requested effective date: ____ / ____ / ____

SECTION 3 – PLAN INFORMATION

Plan choice	Plan #	In-network deductible		Out-of-pocket maximum	Coinsurance
		Individual	Family		
<input type="checkbox"/> MultiChoice SM POS					

SECTION 3 – PLAN INFORMATION (continued)

Plan choice	Plan #	In-network deductible		Out-of-pocket maximum	Coinsurance
		Individual	Family		
<input type="checkbox"/> Added Choice® POS					
<input type="checkbox"/> Added Choice Triple Option					
<input type="checkbox"/> PPO					

SECTION 4 – PREMIUM

Monthly rates:	Employee only (EE): \$	EE + spouse (SP): \$	EE + Child(ren) (CH): \$	EE + SP + CH: \$
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SECTION 5 – GROUP ACKNOWLEDGEMENT

I understand and agree, on behalf of the employer, that the statements in this application are true and complete to the best of my knowledge and belief. I understand and agree that such statements and answers: (a) will become part of any Group Agreement which may be ultimately issued by KFHP; (b) will become part of any policy or policies which may be ultimately be issued by KPIC; and (c) are made to induce KPIC and/or KFHP to issue the group coverage, for which this application is made.

Likewise, by payment of the first premium and my subsequent acceptance of the Group Policy, I hereby designate KPIC as the "named fiduciary" for appeals arising under the Group Policy, if applicable.

Signed at: _____ on ____/____/____
City State Month Day Year

By (print full name of officer or person authorized to purchase plan): _____

Signature: _____ Title: _____

SECTION 6 – BROKER INFORMATION

Broker name: Steven J. Roper

Broker firm/company name: Roper Insurance

Broker address: 116 Inverness Dr. East #265 Englewood Co 80112
Street City State Zip

OR L&D license number: _____ (or) Kaiser Permanente broker number: 442113

I authorize the individual named above to act as a broker of record for our health plan coverage, through KFHP, and KPIC, effective: _____

Signed at: Englewo on ____/____/____
City State Month Day Year

By: _____ Title: _____
(Signature of officer or person authorized to purchase plan)

SECTION 7 – COMMENTS/SPECIAL INSTRUCTIONS

**Colorado
Commission Disclosure
Small Group Accounts < 50 Lives**

As part of this health insurance solicitation, we are required by state law to advise you that should you purchase health insurance from me, that Roper Insurance & Financial Services will receive compensation in the form of a commission.

Commission Schedules

Aetna	6% or premium paid	
Anthem	\$25 per enrolled employee per month	
Destiny Health	\$25 per enrolled employee per month	
Guardian	<u>Annual Premium</u>	<u>Commission %</u>
	First \$50,000	5.0%
	Next \$200,000	3.5%
	Next \$250,000	2.0%
	Next \$2,000,000	1.0%
	Next \$2,500,000	0.5%
Humana	\$25 per enrolled employee per month	
Kaiser	\$24 - \$27 per Subscriber (based on production)	
PacifiCare	Health Maintenance Organization (HMO) - 4% of Premium	
	Preferred Provider Option (PPO) - 6% of Premium	
Principal Financial	<u>Annual Premium</u>	<u>Commission %</u>
	First \$150,000	5%
	Next \$100,000	3%
	Over \$250,000	1%
Rocky Mountain Health Plans	\$23 per enrolled employee per month	
United Healthcare	\$24 per enrolled employee per month	

I acknowledge receipt of this notice:

Signed: _____ date: _____

Print name: _____

Producer: _____ date: _____

Print name: _____