

# 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 or working 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
<input type="checkbox"/> MultiChoice <sup>SM</sup> POS		Individual		
		Family		

**SECTION 3 – PLAN INFORMATION** (continued)

Plan choice	Plan #	In-network deductible		Out-of-pocket maximum	Coinsurance
<input type="checkbox"/> Added Choice® POS (Large groups only)		Individual			
		Family			
<input type="checkbox"/> PPO		Individual			
		Family			
<input type="checkbox"/> PPO Out-of-Area		Individual			
		Family			

**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: \_\_\_\_\_

Broker firm/company name: \_\_\_\_\_

Broker address: \_\_\_\_\_  
Street City State Zip

or L&D license number: \_\_\_\_\_ (or) Kaiser Permanente broker number: \_\_\_\_\_

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: \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
City State Month Day Year

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

**SECTION 7 – COMMENTS/SPECIAL INSTRUCTIONS**

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