

Enrollment provisions

ENROLLMENT ELIGIBILITY AND COST CONTRIBUTIONS

The following summary provides some important details about enrollment eligibility, employer contributions, and payroll deductions to cover the cost of coverage. Please see your Group Agreement for more information about eligibility, participation, and contribution requirements.

COMPANY ELIGIBILITY FOR COVERAGE

Your company qualifies for our small group coverage if you have at least two but no more than 50 full-time employees worldwide (working at least 30 hours per week).

CALIFORNIA ENROLLMENT GUIDELINES

Your group must enroll a minimum of one employee in our small group coverage, with at least 70 percent of eligible employees covered by any group health plan (that is, through their employer or their spouse's employer, etc.).

EMPLOYEE AND FAMILY DEPENDENT ELIGIBILITY

Employees and their family dependents (spouse/domestic partner, unmarried children to age 19, and students to age 24) are eligible for coverage if the employee lives or works within our ZIP code Service Areas listed on the next page.

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, unless enrollment is due to new dependents or loss of other coverage.

EMPLOYER'S CONTRIBUTION AND PAYROLL DEDUCTION

Your minimum cost contribution must be the greater dollar amount of the following scenarios: (a) 50 percent of the employee-only rate for the less-than 30 age-band, or (b) the required equal dollar amount contribution to an alternate plan your company may offer.

Any part of the cost not paid by your company must be collected from the employees through payroll deduction.

FULL-MONTH COVERAGE

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

ZIP CODE SERVICE AREAS

All new membership in Kaiser Permanente is limited to individuals who live or work within the following ZIP codes:

SOUTHERN CALIFORNIA REGION

The Service Area is that portion of Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Tulare, and Ventura counties within these ZIP codes:

90001-84	90637-40	91030-31	91392-96	91780	92071-72	92282*	92530-32	92825	93252**
90086-89	90650-52	91040-43	91399	91784-86	92074-75	92284-86*	92543-46	92831-38	93261
90091	90659-62	91046	91401-13	91788-93	92078-79	92292*	92548	92840-46	93263
90093-97	90665	91066	91416	91795	92081-85	92305	92551-57	92850	93268
90099	90670-71	91077	91423	91797-99	92090-93	92307-08	92562-64	92856-57	93276
90101-03	90680	91101-10	91426	91801-04	92096	92313-18	92567	92859-71	93280
90174	90701-03	91114-18	91436	91841	92101-24	92320-22	92570-72	92877-83	93285
90185	90706-07	91121	91470	91896	92126-40	92324-26	92581-87	92885-87	93287
90189	90710-17	91123-26	91482	91899	92142-43	92329	92595-96	92899	93301-09
90201-02	90720-21	91129	91495-97	91901-03	92145	92333-37	92599	93001-07*	93311-14
90209-13	90723	91131	91499	91908-17	92147	92339-41	92602-07	93009*	93380-90
90220-24	90731-34	91175	91501-08	91921	92149-50	92345-46	92609-10	93010-12	93501-02
90230-33	90740	91182	91510	91931-33	92152-55	92350	92612	93015-16	93504-05
90239-42	90742-49	91184-89	91521-23	91935	92158-79	92352	92614-20	93020-21	93510
90245	90755	91191	91526	91941-47	92182	92354	92623-30	93022*	93518-19
90247-51	90801-10	91201-10	91601-12	91950-51	92184	92357-59	92637	93030-36*	93531-32
90254-55	90813-15	91214	91614-18	91962-63	92186-87	92369	92646-63	93040	93534-36
90260-67	90822	91221-22	91701-02	91976-80	92190-99	92371-78	92672-79	93041-44*	93539
90270	90831-35	91224-26	91706	91987	92201-03*	92382	92683-85	93060-61*	93543-44
90272	90840	91301-13	91708-11	91990	92210-11*	92385-86	92688	93062-66	93550-53
90274-75	90842	91316	91714-16	92007-09	92220	92391-95	92690-94	93093-94	93560-61
90277-78	90844-48	91319-22	91722-24	92013-14	92223	92397	92697-98	93099	93563
90280	90853	91324-31	91729-35	92018-27	92230*	92399	92701-12	93203	93581
90290-96	90888	91333-35	91737	92029-30	92234-36*	92401-08	92725	93205-06	93584
90301-13	90899	91337	91739-41	92033	92240-41*	92410-15	92728	93215-16	93586
90397-98	91001	91340-46	91743-50	92037-40	92247-48*	92418	92735	93220	93590-91
90401-11	91003	91350-65	91752	92046	92252-56*	92420	92780-82	93222	93599
90501-10	91006-07	91367	91754-56	92049	92258*	92423-24	92799	93224-26	
90601-10	91009-12	91371-72	91758-59	92051-52	92260-64*	92427	92801-09	93238	
90612	91016-17	91376-77	91761-73	92054-58	92268*	92501-09	92811-12	93240-41	
90620-24	91020-21	91380-88	91775-76	92064-65	92270*	92513-19	92814-17	93243	
90630-33	91023-25	91390	91778	92067-69	92274-78*	92521-22	92821-23	93250-51	

*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). Members will be contacted after enrollment regarding Plan Physician (Affiliated Physician) selection.

**The portion that lies within Ventura is not in the Service Area.

NORTHERN CALIFORNIA REGION

The Service Area is that portion of Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba counties within these ZIP codes:

93230	93701-12	94035	94234-37	94585-92	94937-42	95108-42	95304	95421	95628	95765
93232	93714-18	94037-45	94239-40	94595-99	94945-57	95148	95307	95425	95630	95776
93242	93720-22	94059-67	94243-50	94601-15	94960	95150-61	95313	95430-31	95632-35	95798-99
93601-02	93724-29	94070-71	94252-54	94617-27	94963-66	95164	95316	95433	95638-41	95812-38
93604	93740-41	94074	94256-59	94643	94970-79	95170-73	95319-20	95436	95645	95840-43
93606-07	93744-45	94080	94261-63	94649	94998-99	95190-94	95323	95439	95648	95851-53
93609	93747	94083	94267-69	94659-62	95002	95196	95326	95441-42	95650-52	95857
93611-14	93750	94085-90	94271	94666	95008-09	95201-13	95328-30	95444	95655	95860
93616	93755	94096	94273-74	94701-10	95011	95215	95336-37	95446	95658-64	95864-67
93618-19	93760-62	94098-99	94277-80	94712	95013-15	95219-20	95350-58	95448	95667-74	95873
93623-27	93764-65	94101-12	94282-91	94720	95020**-21	95227	95360-61	95450	95676-78	95887
93630-31	93771-80	94114-47	94293-99	94801-08	95026	95230-31	95363	95452	95680-83	95894
93637-39	93784	94150-72	94301-10	94820	95030-33	95234	95366-68	95462	95686-88	95899
93643-46	93786	94175	94401-09	94850	95035-38	95236-37	95376-78	95465	95690-98	95903
93648-54	93790-94	94177	94497	94875	95042	95240-42	95380-82	95471-73	95703	95961
93656-57	93844	94188	94501-03	94901	95044	95253	95385-87	95476	95722	
93660	93888	94199	94506-31	94903-04	95046	95258	95391	95486-87	95736	
93662	94002-03	94203-09	94533-53	94912-15	95050-56	95267	95397	95492	95741-43	
93666-69	94005	94211	94555-66	94920	95070-71	95269	95401-09	95602-05	95746-47	
93673	94010-12	94229-30	94567*	94922-31	95101-03	95290	95416	95607-21	95757-59	
93675	94013-31	94232	94568-83	94933	95106	95296-98	95419	95623-26	95762-63	

*The Knoxville community, which lies within Pope Valley ZIP code 94567, is not in the Service Area.

**The Bells Station community, which lies within Gilroy ZIP code 95020, is not in the Service Area.

Service Areas as of 7/1/2004. Please call our Member Service Call Center at 1-800-464-4000 if you have questions.

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

■ **Effective date** _____

Please select and circle one plan

Deductible Plans	\$30/\$1,000 Plan		\$20/\$1,000 Plan		\$10/\$1,000 Plan
Copayment Plans	\$50 Plan	\$30 Plan	\$20 Plan	\$15 Plan	\$5 Plan
Paired Option	Paired Option				
POS Plans*	POS Plan		POS Plan with Infertility		

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

<input type="checkbox"/> Check here to select the <i>optional</i> Delta Dental coverage, underwritten by KPIC. Select and circle one plan below.			<input type="checkbox"/> Check here to select the <i>optional</i> Chiropractic benefit.		
Plan C	Plan D	Plan E	Plan E w ortho (requires at least 25 subscribers)	(If your group selects a dental plan or chiropractic benefit, each subscriber and dependent enrolling in the medical plan must also enroll in the dental plan or chiropractic benefit.)	
Plan D PPO 1500	Plan E PPO 1000	Plan E PPO 1500			

Business name _____

Address (in California) _____

City _____ State _____ ZIP _____

Phone _____ Fax number _____ E-mail (By giving Kaiser Permanente your e-mail address, you agree to receive e-mail from us.) _____

Type of business or SIC/NAICS code (optional) _____ In business since _____

Check here if you had previous group insurance through Kaiser Permanente. (Please provide your previous Kaiser Permanente Group Number _____.) Check here to offer Domestic Partner coverage

■ If your group has 20 or more employees, select one of the following choices for administering COBRA: Group-administered billing Kaiser Permanente-administered billing

Principal Owners/Corporate Officers

1. Name _____ Title _____ Social Security number/EIN _____

2. Name _____ Title _____ Social Security number/EIN _____

- 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) Date of hire 30 days 60 days 90 days 180 days 365 days
- Mr. Mrs. Ms.

■ Billing statements to be mailed to (person/title) Address _____ City _____ State _____ ZIP _____

■ Contract to be mailed to (person/title) Address _____ City _____ State _____ ZIP _____

Check here if this person is authorized to make changes to your contract.

■ Interested Party (An Interested Party is authorized to access information about your account.)

Please complete, sign, and date below. 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 _____

ACal L&D Lic. # _____ Exp. date _____ Kaiser Permanente Broker ID # _____

As company principal/corporate officer, having authority to contract with Kaiser Foundation Health Plan, Inc., I agree that my company will contribute at least 50 percent of the employee-only rate for the < 30 age-band for each subscriber, that our prepaid monthly dues will be submitted by the 30th of each month prior to the month of coverage, that my company will use enrollment application forms that are provided or approved by Health Plan, and that my company will abide by the contract provisions.

Binding Arbitration Agreement: Disputes between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to the *Group 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 *Group Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under the *Group Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members
- If the Member's Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under this Section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid.

If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice. Note: Binding arbitration does not apply to disputes with Kaiser Permanente Insurance Company (KPIC) or disputes with out-of-network providers.

X
 Employer Signature _____ Title _____ Date _____



Health Questionnaire

Please complete this section ONLY if your group has between 16 – 50 enrolling employees:
Groups with 15 or fewer enrolling employees are not required to complete this section.

Please answer the following questions to the best of your knowledge for **enrolling employees and dependents only**. All questions must be answered to establish a final rate for your group. Incomplete information may affect your group's rate or delay the enrollment of your group.

Business name _____

Address (in California) _____

City _____ State _____ ZIP _____

Phone (_____) _____ Fax number (_____) _____

Principal Owners/Corporate Officers

1.	_____	_____	_____
	Name	Title	Social Security Number
2.	_____	_____	_____
	Name	Title	Social Security Number

1.	How many employees/dependents are currently pregnant?	<input type="checkbox"/> _____
		<input type="checkbox"/> None
2.	How many employees/dependents have been advised to have surgery in the last six months or anticipate hospitalization for any other reason?	<input type="checkbox"/> _____
		<input type="checkbox"/> None
3.	How many employees/dependents have been treated for a serious illness (physical or mental) and/or had more than \$5,000 of medical expenses or been hospitalized in the past 12 months?	<input type="checkbox"/> _____
		<input type="checkbox"/> None
4.	How many employees are not actively performing their duties full-time due to a disabling illness or injury?	<input type="checkbox"/> _____
		<input type="checkbox"/> None
5.	How many employees are currently confined to a hospital or treatment facility?	<input type="checkbox"/> _____
		<input type="checkbox"/> None

I certify that, to the best of my knowledge, the above information is true and complete. Any information provided will not result in a denial of coverage. The information will only be used for rating purposes and not for any other purpose.

Employer Signature _____ Title _____ Date _____



KAISER PERMANENTE®

Proprietor/Partner/Corporate Officer Form

(If not listed on DE 6)

To establish the relationship between proprietors, partners, and/or corporate officers to the below referenced company, please complete and return this form.

I attest that, although my name does not appear on the DE 6 wage report of the below-named company, the following conditions are true:

1. I am a sole proprietor, partner of a partnership, or corporate officer.
2. I actively work at the below-named company.
3. I draw wages, dividends, or other distributions from the below-named company on at least a monthly basis and am not eligible for group health coverage from any other employment.
4. I work on a permanent, full-time basis for the below-named company for at least 20 hours per week.
5. I satisfied the designated waiting period before coverage becomes effective.
6. I must provide, upon request from Kaiser Permanente, a copy of my company's fictitious name statement, DBA, legal partnership agreement and schedule K, Articles of Incorporation, Schedule C, current business license, or current professional license.
7. For Corporate Officers, please state reason(s) your name does not appear on the below-named company's DE 6. _____

I understand that this information may be subject to verification and agree to provide Kaiser Foundation Health Plan, Inc. with any information necessary to do so. I also understand that failure to meet the above conditions may result in denial or termination of group health coverage from Kaiser Foundation Health Plan, Inc. for the below-named company.

Proprietor, Partner, or Corporate Officer's Signature

Date

Print Proprietor, Partner, or Corporate Officer's Name (printed)

Title

Company Name



DE 6 QUARTERLY WAGE REPORT

PLEASE TYPE THIS FORM—DO NOT ALTER PREPRINTED INFORMATION

Approved Extension To _____

Serving the People of California

You must FILE this report even though you had no payment. If you had no payment, complete forms C and I. Instructions for completion are available on the back of this form.

QUARTER ENDED MARCH 31, 2002 DUE APR 1, 2002 DELIQUENT IF NOT POSTMARKED OR RECEIVED BY MAY 1, 2002

EMPLOYER ACCOUNT NO.

123-4567-8

JOHN SMITH
SMITH ENTERPRISES
123 HEALTH AVENUE
LOS ANGELES, CA 92068



DO NOT ALTER THIS AREA

P1	C	S	W	A
Mo.	Day	Yr.	WIC	
=	=	=		

B. NUMBER OF EMPLOYEES earning wages during or receiving pay for the pay periods that include the 12th day of calendar month.

1st Mo. 7 2nd Mo. 6 3rd Mo. 8

C. NO PAYROLL D. OUT OF BUSINESS / FINAL REPORT

A. Check ONE of the boxes below to indicate the type of subject wages and/or withholding you are reporting on this page. (See instructions for term A)

Page number _____ of _____

1. U1 AND D1 WAGES 2. U1 WAGES ONLY 3. D1 WAGES ONLY 4. U1 AND VOLUNTARY PLAN D1 WAGES 5. PERSONAL INCOME TAX WITHHELD

E. SOCIAL SECURITY ACCOUNT NUMBER	F. EMPLOYEE NAME		G. TOTAL SUBJECT WAGES PAID THIS QUARTER		H. CALIFORNIA PERSONAL INCOME TAX WITHHELD THIS QUARTER	
	First Initial	Last Name				
123-45-6789	I	Seymore Declining	4,839	00	106	37
111-22-3333	M	Feelgood Kaiser	3,454	65	32	66
222-33-4444	J	Wayne Permanente	4,460	00	36	50
555-55-5555	J	Kennedy Kaiser Permanente	6,846	34	100	20
444-33-2222	I	Care Terminated	287	86	0	00
111-33-2222	A	Easy Part-time	40	50	0	00
555-11-5555	B	Valor Part-time	5,663	74	64	98
001-11-2222	D	Best Kaiser Permanente	800	00	281	88
		Kaiser Permanente				

I. I declare that the information herein is true and correct to the best of my knowledge and belief.

Date _____ Phone (____) _____
Title _____
(Owner, Accountant, Preparer, etc.)
Signature _____

J. TOTALS - THIS PAGE ONLY		K. TOTALS - THIS PAGE ONLY	
33,392	09		

L. GRAND TOTALS - ALL PAGES		M. GRAND TOTALS - ALL PAGES	
33,392	09	622	59