KAISER PERMANENTE®

Small Business

EMPLOYER'S CONFIRMATION OF WORKERS' COMPENSATION

COMPANY INFORMATION

Company name		Customer ID
Phone	Fax	Email

WORKERS' COMPENSATION

All employees must be covered by workers' compensation, unless not required to be covered by law. I attest that the following information is correct.

☐ Workers' compensation carrier: _____

☐ Exempt – I am exempt from providing workers' compensation coverage for the following reason:

_____

Please note: Owner/partners are covered by Kaiser Permanente 24 hours a day while at work and are not required to cover themselves for workers' compensation.

SIGNATURE

I affirm that I have authority to contract with Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company on behalf of the group. 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 Health Plan for the above-named company.

Authorized company signer (please print name)	Title
Signature **X**	Date