KAISER PERMANENTE®

Small Business

PARTICIPATION AND CONTRIBUTION ATTESTATION

COMPANY INFORMATION

Company name		Customer ID
Phone	Fax	Email

EMPLOYEE COUNT

Please provide the total number of employees **(full-time and part-time).**

Authorized company signer's initials _____ Total _____

If your total number of employees noted above is more than 100, please provide the total number of **full-time and full-time-equivalent employees** on the line below. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to the California Small Group Law (1357.500)(k)(3) or your legal counsel. To qualify for small group coverage, your company must have at least 1 but no more than 100 full-time and full-time-equivalent employees on at least 50% of the previous calendar quarter or previous calendar year.

Authorized company signer's initials _____ Total _____

COMPANY PREMIUM CONTRIBUTION

The contribution can be a percentage or a fixed dollar amount. Minimum contribution must be at least 50% of the employee's premium for the lowest-priced Kaiser Permanente medical plan offered by the employer.

Will you be offering dependent coverage? ☐ Yes ☐ No*

*For groups with 49 employees or less, dependent coverage is optional. Employees may not enroll any dependents unless coverage is offered by employer. Groups with 50 or more full-time and full-time-equivalent employees are subject to Employer Shared Responsibility and therefore are required to offer dependent children coverage.

Company contribution for employees:	Company contribution for dependents is optional, if dependent coverage is offered. (enter 0 if none):
$ or % of the premium	$ or % of the premium

Percentage of the premium is based on the following **(select 1 only)**:

☐ Lowest-priced Kaiser Permanente medical plan offered by the employer ☐ All Kaiser Permanente medical plans offered by the employer

SIGNATURE

I affirm that I have authority to contract with Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Permanente Insurance Company (KPIC) on behalf of the group.

I agree that:

I have read, understood, and agreed to Kaiser Permanente's Small Business Guidelines, which is available at kp.org/smallbusinessguidelines/ca.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I will comply with the 70% participation provision, as outlined in the small business guidelines.

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. I understand that if I performed an act or practice constituting fraud or made an intentional misrepresentation of material fact, any coverage approved by KFHP or KPIC may be canceled or the applicable premiums/rates may be adjusted.

I understand that if KFHP or KPIC intends to rescind or terminate my coverage, I will be sent a notice via regular certified mail at least 30 days prior to the effective date of the rescission or termination explaining the reasons for the intended rescission or termination and notifying me of my right to appeal that decision to the Department of Managed Health Care director or the Department of Insurance commissioner. I understand that after 24 months following the issuance of my KFHP health plan contract/KPIC health insurance policy, KFHP/KPIC shall not rescind my plan contract/policy for any reason, and shall not cancel my plan contract/policy, limit any of the provisions of my plan contract/policy, or raise premiums on my plan contract/policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

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