

### Instructions

Application is made to KPS Health Plans for a new health care contract or modification of an existing health care contract, the provisions of which shall be applicable to all eligible classes of employees. *To complete application electronically, TAB through document to fill-in all fields. Once completed, print application, sign and date where indicated and mail or fax to KPS.*

In order to enroll your small group, all required forms, documentation and the first month's premium payment (see **Employer Group Documentation Requirements**) must be postmarked or received by KPS Health Plans on or before the 20<sup>th</sup> of the month for coverage to be effective the first day of the following month. In addition to completing the entire Small Group Master Application, the following information must be provided to enroll **new groups**:

- Enrollment Applications for each employee       Quoted Rate       Business Verification       Premium Payment

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### Section 1. Employer Group Status

- New Employer Group       New Affiliate or Subsidiary       Other

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### Section 2. General Employer Group Information

Full legal business name		REQUESTED EFFECTIVE DATE
Primary business address (street/city/state/zip)		
Billing address, if different from business address (street/city/state/zip)		
Name of owner/partner/corporate officer	Title	Phone
Name of primary contact person	Title	Phone
Name of alternate contact person	Title	Phone
Nature of business		

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### Section 3. Affiliate or Subsidiary Information

Full legal business name		<input type="checkbox"/> Affiliate <input type="checkbox"/> Subsidiary
Primary business address (street/city/state/zip)		
Nature of business (if different from above)		NAICS
Full legal business name		<input type="checkbox"/> Affiliate <input type="checkbox"/> Subsidiary
Primary business address (street/city/state/zip)		
Nature of business (if different from above)		NAICS

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**Section 4. Insurance Producer Information (if applicable)**

"Insurance Producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance. "Insurance producer" does not include title insurance agents.

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Name of insurance producer

KPS insurance producer #

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Name of firm

Phone

You, insurance producer, certify that you have met with the group submitting this agreement and that you have fully explained its contents. You have discussed coverage, eligibility, any waiting periods for pre-existing conditions, the effect of misrepresentations and termination provisions.

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Signature of insurance producer

Date

**Appointment Certification:**

I certify that the above-named insurance producer has been retained as the insurance producer with respect to the coverage described in this Small Group Master Application. The above-named insurance producer shall remain the Insurance Producer-of-Record with respect to the coverage described in this Small Group Master Application until such time as written notice is provided to KPS by either party.

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Signature of authorized group representative

Print name and title

Date

*KPS will pay any applicable commissions due to the above-named insurance producer on behalf of the group until such time as KPS receives written notice that the insurance producer is no longer the Insurance Producer-of-Record for the group.*

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**Section 5. Eligibility, Participation, and Contribution Requirements (Note – Please complete the Employer Group Eligibility Requirements)**

KPS Health Plans is a health care service contractor licensed and marketing our small employer group health plans in the state of Washington.

**Employee:** any individual employed by the employer group.

**Eligible Employee:** an Employee who meets the employer group eligibility requirements.

**Employer Group Eligibility Requirements:**

- A. To be considered eligible, employer group requires Employee to work a minimum of \_\_\_ hours per week.
- B. Independent contractors are not eligible. Persons whose earnings are based solely on income reported on IRS form 1099 are not eligible.
- C. Other eligibility requirements of the employer group (e.g., full or part time status) \_\_\_\_\_ (please specify)

**KPS Group Eligibility Requirements:**

- A. Employer groups must be headquartered in the state of Washington and be actively engaged in the business presented (documentation required).
- B. Effective June 12, 2008, an employer group means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that: (i) employed an average of at least two (2) but no more than fifty Employees during the previous calendar year; and (ii) employed at least two Employees on the first day of the contract year; (iii) is not formed primarily for purposes of buying health insurance; and (iv) a bona fide employer-Employee relationship exists. In determining the number of Employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. (signed certification and documentation required).
- C. The maximum allowed percentage of Employees living or working outside of the KPS marketing area is 25%.
- D. To enroll new Employees, KPS Health Plans must receive a completed Enrollment Application from the employer group within 31 days following completion of the probationary period indicated in Section 6 of this application. Applications received after the 31 days will require the Employee to wait to enroll for coverage until the next Open Enrollment Period.
- E. Covered Employees who make application for the addition of newborn children, legally adopted children, and children for whom the Employee has assumed a legal obligation for primary support in anticipation of adoption that will result in an additional monthly charge, must submit an Enrollment Application form to KPS Health Plans through the employer group. KPS Health Plans must receive an Enrollment Application form, through the employer group, within 60 days of the qualifying event. Application for newly-acquired spouses and stepchildren must be received by KPS Health Plans, through the employer group, within 31 days of the qualifying event.
- F. Premium payment, if applicable, must accompany all enrollment applications for coverage, within the specified time frames.

**KPS Participation Requirements:**

- A. The minimum required level of Employee participation for employer groups of up to 3 is 100% of Eligible Employees.
- B. The minimum required level of Employee participation for employer groups of 4-50 is 75% of Eligible Employees.  
Note: See above for definition of Eligible Employee
- C. Employees covered by CHAMPUS/Tricare, Medicare, an HMO, or other similar employer group coverage through a spouse or parent are not required to participate in the plan but may choose to participate if all eligibility requirements are met.

**KPS Employer Group Contribution Requirements:**

The minimum required employer group contribution toward the monthly cost of Employee coverage is 75%.

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**Section 6. Employer Group's Probationary Period Requirements** (The time period required by the employer group before a new Employee is eligible for employer group sponsored benefits.)

- A. **Employer group's probationary periods begin on:** the 1<sup>st</sup> day of employment. The employer group imposed probationary period applies toward satisfying any applicable waiting period for pre-existing conditions. Changes to the probationary period will only be allowed during the employer group's open enrollment period.
- B. **Following the employer group's probationary period, Eligible Employee coverage begins on:** the 1<sup>st</sup> day of the month following the completion of the employer group's probationary period.
- C. **Employee classifications:** employer groups may list Employees in different classifications (e.g., salaried, hourly) for the purpose of offering different employer group probationary periods to each Employee classification, or elect to offer the same employer group probationary period for all Eligible Employees. If all Employees will have the same probationary period, please complete Subsection 1. If you are electing to offer different employer group probationary periods for each Employee classification, please complete Subsection 2.

**Subsection 1. Employer group's probationary period ends for all Eligible Employees on the 1<sup>st</sup> of the month following:**

date of employment  30 days  60 days  90 days  120 days  180 days  Other \_\_\_\_\_

**Subsection 2. Employer group's probationary period by Employee classification**

Describe each Employee classification and indicate the employer group's probationary period for each classification below.

**Classification**

**Employer Group's Probationary Period Ends on the 1<sup>st</sup> of the month following:**

1.  date of employment  30 days  60 days  90 days  120 days  180 days  Other \_\_\_\_\_

2.  date of employment  30 days  60 days  90 days  120 days  180 days  Other \_\_\_\_\_

3.  date of employment  30 days  60 days  90 days  120 days  180 days  Other \_\_\_\_\_

- D. **Waiving employer group's probationary period (For New Employer Groups Only):** Are you waiving the employer group's probationary period for all Employees at initial enrollment?  
 Yes, waive the employer group's probationary period for all current Eligible Employees.  
 No, the employer group's probationary period, as stated in Subsection 1) or 2), will apply to all current Eligible Employees.
- E. **Employee Transfers** (if applicable, see Section 5): For Employees transferring from part-time to full-time status, the following employer group's probationary period should apply:  
 Employer group's probationary period begins upon the date Eligible Employee transferred to full-time status.  
 Employer group's probationary period is retroactive to the Eligible Employee's original date of hire.

**Section 7. Pre-existing Conditions**

There is up to a nine (9) month waiting period for pre-existing conditions unless your Eligible Employees and their eligible dependents had health insurance prior to enrolling in this KPS plan and the break in coverage does not exceed three (3) months. If there is an employer group imposed probationary period, the pre-existing condition waiting period begins the first day of the probationary period. **Each subscriber must provide us with a Certificate of Creditable Coverage from the prior plan to have this waiting period waived or credited.** (All health carriers and HMOs are required to provide these certificates to members.) Other forms of proof of prior coverage may be provided, such as pay stubs, Explanation of Benefits forms, benefit termination from a prior health plan, or verification by a doctor or provider of the prior coverage. No credit will be given toward waiting periods for listed conditions, unless transferring from another KPS medical plan without a lapse in coverage. *Please see the reverse side of the KPS Enrollment Application for a definition of Creditable Coverage.*

**Section 8. Continuation of Coverage**

**TEFRA/COBRA (Tax Equity and Fiscal Responsibility Act of 1982/Consolidated Omnibus Budget Reconciliation Act of 1985)**

- A. Does your company have 20 or more full-time and/or part-time Employees?  Yes  No
- B. Is your company subject to Federal TEFRA laws?  Yes  No
- C. Is your company subject to COBRA laws?  Yes  No

*TEFRA/COBRA regulations may apply to your employer group, even if you have fewer than 20 Employees enrolled through this coverage. If you have questions regarding TEFRA or COBRA, contact your legal counsel.*

**TEMPORARY CONTINUATION OF COVERAGE (TCC)**

For employer groups with less than 20 Employees, enrolled Eligible Employees have the option, upon termination, to continue coverage for a maximum of three (3) months from the date of qualifying events listed in the member Benefits Booklet. Employer group is responsible to process any self-pay premium payment. No personal checks will be accepted.

- If you are not a COBRA-eligible employer group (employer groups with less than 20 Employees), will you apply TCC coverage for all Eligible Employees?  
 Yes. TCC coverage will apply to all Eligible Employees.  No. TCC will not apply to any Eligible Employee.

**Section 9. Employee Census**

Please list all Employees, whether enrolling for coverage or not. Please complete the **Status** column with one of the following:

**E**= Employee; **T**=Temporary Employee working less than five months per year; **I**=Independent contractor affiliated with the employer group (ineligible); **L**=Legally required continuation (i.e. COBRA); **O**=Other (please specify, owner or officer).

	Employee Name	Hire Date	Hours Worked Per Week	Status	Current Insurance Coverage (for those Eligible Employees NOT enrolling with KPS)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
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25					
26					
27					

Use additional pages if necessary.

KPS Health Plans reserves the right to request a state wage and/or tax statement or other documentation at any time to verify current and future participation and eligibility.

I confirm that \_\_\_\_\_ (exact legal name of company) is complying with the eligibility and participation requirements of KPS Health Plans, as outlined in this Small Group Master Application. The above listing includes: (1) all Employees, owners, partners, managers, and corporate officers who are actively working for this company on a regular basis, whether or not they are eligible to be covered by this plan, and (2) persons covered due to requirements of law (e.g., COBRA).

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**Section 10. Coverage Options (Plan Choice)** **Solutions Plus**

Home Health, Hospice, Pre-natal testing, and Temporomandibular Joint (TMJ) Dysfunction coverage included.

Deductible (Individual/Family)  \$500/\$1,500  \$1,000/\$3,000  \$1,500/\$4,500  
Coinsurance Maximum (Individual/Family)  \$2,000/\$6,000  \$5,000/\$15,000  
Prescription Drug Options (Must choose one option)  \$10/\$30/\$50  \$15/\$40/\$60  
Additional Coverage Option  Vision 100

 **Solutions Basic**

Home Health, Hospice, and Pre-natal testing coverage included.

Deductible (Individual/Family)  \$500/\$1,500  \$1,000/\$3,000  \$1,500/\$4,500  
Coinsurance Maximum (Individual/Family)  \$3,000/\$9,000  \$5,000/\$15,000  
Prescription Drug Options (Must choose one option)  \$10/\$30/\$50  \$15/\$40/\$60  
Additional Coverage Option  Vision 100

 **The Healthy Investor™ Small Group HSA – 80**

Home Health, Hospice, Pre-natal testing, and Temporomandibular Joint (TMJ) Dysfunction coverage included.

Option	Deductible (Individual/Family)	Out-of-Pocket Maximum (includes Deductible)
<input type="checkbox"/> 1	\$1,500/\$3,000	\$4,000/\$8,000
<input type="checkbox"/> 2	\$2,000/\$4,000	\$4,500/\$9,000
<input type="checkbox"/> 3	\$2,500/\$5,000	\$5,000/\$10,000
<input type="checkbox"/> 4	\$3,000/\$6,000	\$5,500/\$11,000

Additional Coverage Option  Vision 100

 **The Healthy Investor™ Small Group HSA – 100**

Home Health, Hospice, Pre-natal testing, and Temporomandibular Joint (TMJ) Dysfunction coverage included.

Option	Deductible (Individual/Family)	Out-of-Pocket Maximum (includes Deductible)
<input type="checkbox"/> 1	\$4,000/\$8,000	\$4,000/\$8,000
<input type="checkbox"/> 2	\$5,000/\$10,000	\$5,000/\$10,000

Additional Coverage Option  Vision 100

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**Optional Dental Coverage - Washington Dental Service** (9706 Fourth Avenue NE, Seattle, WA 98115-2157) Please see sales brochure for information on this option. If a dental plan is chosen, all members (including dependents) enrolling in a medical plan will also be enrolled in the dental plan.

- None  
 Dental Only  
 Dental with Temporomandibular Joint (TMJ) Dysfunction coverage

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**Section 11. On-the-Job Coverage (owners and officers only)**

If you opt to provide On-the-Job Coverage, please list all individuals who are exempt from coverage under state workers' compensation programs and who are applying for coverage under this employer group plan (include additional sheet if necessary).

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Last name, first name, middle initial	Position title	Social Security Number
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Last name, first name, middle initial	Position title	Social Security Number
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Last name, first name, middle initial	Position title	Social Security Number
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Last name, first name, middle initial	Position title	Social Security Number
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NOTE: I understand that it is my responsibility to inform KPS Health Plans within 60 days of a change in the owners or officers for this group.

**Section 12. Agreement to Contract**

This application becomes an agreement to provide health care coverage after all of the following:

- A. The application is signed by an accountable officer or other person authorized by the employer group to make such an agreement.
- B. The application and documentation is received and approved by KPS Health Plans.
- C. The initial month's premium is received by KPS Health Plans.
- D. The employer group agrees to maintain the applicable enrollment described in Section 5 "Eligibility, Participation, and Contribution Requirements."

**Late Payments/Cancellation**

If the monthly premium is not received by the due date, the employer group contract holder will be granted a grace period of up to ten (10) days, during which the contract shall not be terminated. Except for this grace period, the contract is immediately cancelable by KPS Health Plans without notice upon non-payment of the monthly premium, retroactive to the last paid through date. No further liability for claims will accrue to KPS Health Plans. In addition, the employer group agrees to secure such participatory payment through payroll deduction and make payment in whole to KPS Health Plans for all monthly premiums.

**Receipt and Examination of Contract**

Upon completion of the application process, KPS will provide the employer group contract holder with a contract describing the details of the health care coverage. It is understood and agreed that the group contract holder may return the contract to KPS within ten (10) days from the date it is received if it is not satisfied with it for any reason. Immediately upon such return by delivery or mail, the monthly premium will be refunded and the contract shall be deemed null and void. **After the ten (10) day examination period has expired, return of the contract signed by an authorized employer group representative, or non-refund of the first month's premium shall constitute acceptance of all terms and conditions of the contract.**

As an authorized representative of the employer group, I have read this application and agree to the terms and certify that all my statements are true and complete. I am in compliance with any federal or state health benefit plan provisions that apply to the employer group. I understand that if the above information is not complete or is not provided to KPS Health Plans in a timely manner, then coverage does not have to be offered or continued. I understand it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. All prior applications, to the extent that you have not made changes to them in this application, remain in full force and effect.

\_\_\_\_\_  
Print name of employer group representative

\_\_\_\_\_  
Title of employer group representative

\_\_\_\_\_  
Signature of employer group representative

\_\_\_\_\_  
Date

KPS USE ONLY	DATE RECEIVED	INFORMATION COMPLETE Y N	DATE MISSING INFORMATION RECEIVED	PAID
GROUP NO.	EFFECTIVE DATE	NAICS	AE/AM CODE	MISC. CODE