KAISER PERMANENTE®

Small Business
CHANGE OF OWNERSHIP

Effective date ____/____/____

Purchaser ID (PID) _____

INSTRUCTIONS

Please fax the complete bill of sale, purchase agreement, or buy-sell agreement with all required signatures along with this form to your Kaiser Permanente sales representative or your broker.

Upgrades to plans are not allowed midyear.

Your new contract will mirror your existing contract, along with the waiting periods, plan selections, and company contribution.

1 COMPANY INFORMATION

Company name

Doing business as (DBA) | Website

Type of company: ☐ Corporation ☐ Sole proprietorship ☐ Partnership ☐ Limited liability company (LLC) ☐ Other:

In business since: / / | Federal tax ID number | SIC code

Street address (no P.O. boxes) | City | State | ZIP | County

Office phone ( ) – | Fax ( ) –

Do you have workers' compensation coverage? ☐ Yes ☐ No ☐ Pending If *Yes* or *Pending*, name of carrier:

2 COMPANY DEBT/LIABILITIES – KAISER PERMANENTE PREMIUMS

Please choose one of the options below.

☐ Does group assume all past-due premium payment liabilities? If so, group will retain the existing PID.

☐ Does group assume prior owner's liabilities only going forward from the effective date of acquisition of past owner's business? If so, group will be issued a new PID.

3 CONTRACT SIGNER INFORMATION

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name | MI | Last name

Street address (no P.O. boxes) | City | State | ZIP | County

Office phone ( ) – | Ext. | Fax ( ) – | Cell phone ( ) –

How should we correspond with you? ☐ Email ☐ Fax ☐ Mail | Email (required)

4 OTHER MEDICAL INSURANCE

Does your company have or has it ever had group insurance through Kaiser Permanente? If *Yes*, please provide the customer ID and group number.

☐ Yes ☐ No Customer ID #/Group #:

Does your company currently have active group health insurance?

☐ Yes ☐ No Name of carrier: Number of employees enrolled:

Will you be offering another carrier's small group health plan, alongside Kaiser Permanente, to your employees?

☐ Yes ☐ No Name of carrier:

5 CONTRACT DELIVERY PREFERENCE

We will deliver your Kaiser Foundation Health Plan/Kaiser Permanente Insurance Company contracts online in a PDF file at **businessnet.kp.org** unless you indicate below that you would like a printed contract(s) mailed to you.

☐ I want to receive my contract(s) by mail.

6 BILLING CONTACT INFORMATION

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	MI	Last name

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

Street address	City	State	ZIP	County

Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –

How should we correspond with this person? ☐ Email ☐ Fax ☐ Mail	Email (required)

7 INTERESTED PARTY

An *interested party* is an individual authorized to access your group's information, such as enrollees, premium contributions, and plan selections. An interested party may also be authorized to make changes to your contract, such as adding/deleting plans, adding/deleting employees, changing waiting periods, or increasing/decreasing company premium contributions.

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	MI	Last name

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

Street address	City	State	ZIP	County

Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –

How should we correspond with this person? ☐ Email ☐ Fax ☐ Mail	Email (required)

ADDITIONAL INTERESTED PARTY

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	MI	Last name

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

Street address	City	State	ZIP	County

Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –

How should we correspond with this person? ☐ Email ☐ Fax ☐ Mail	Email (required)

8 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

Complete only if you have a broker.

Agent name	License number

Office phone ( ) –	Fax ( ) –	Cell phone ( ) –

Email

Firm name	Kaiser Permanente broker firm ID

Street address	City	State	ZIP	County

If your broker has not registered as a firm or agent with Kaiser Permanente, please advise your broker to call Broker Sales at 800-789-4661, option 4.

9 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

This is an application for coverage only. No contract for coverage will exist until Kaiser Foundation Health Plan, Inc. (KFHP), or Kaiser Permanente Insurance Company (KPIC) has completed its review and communicated to the business applicant or the applicant's broker that the application has been accepted and a group health plan contract/group policy will be issued.

All groups may be subject to a recertification process. Recertification is done to ensure that groups meet all Kaiser Permanente requirements and those set forth in the California Health and Safety Code.

10 SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHP and KPIC, I agree that:

- Prepaid monthly premiums will be posted to Kaiser Permanente's account by the due date on the Kaiser Permanente billing statement.
- My company will use employee enrollment application forms provided or approved by KFHP and KPIC for new employees.
- My company will abide by the contract provisions.

I have read, understood, and agreed to Kaiser Permanente's *Small Business Guidelines*, which may be included with my rate quote or, if not included, is available at **kp.org/smallbusinessguidelines/ca**.

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **kp.org/smallbusiness-sbc/ca**. I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. I understand that if I have misrepresented or omitted any material fact, any coverage approved by KFHP or KPIC may be canceled or the applicable premiums/rates may be adjusted.

AGREEMENT TO THE USE OF BINDING ARBITRATION FOR MEMBER DISPUTES*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and claims that cannot be subject to binding arbitration under governing law*), any dispute between KFHP members or KPIC enrollees, their heirs, relatives, or associated parties (on the one hand) and KFHP, KPIC, Kaiser Permanente health care providers, or other associated parties (on the other hand), for alleged violation of any duty arising out of or related to KFHP membership or KPIC coverage, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. KFHP members and KPIC enrollees 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* or *Certificate of Insurance*.

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

**Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 and 3 of the Point-of-Service (POS) Plan; 2) the Preferred Provider Organization (PPO) and Out-of-Area Indemnity (OOA) plans; and 3) the KPIC Dental plans.*