Kaiser Small Group Online Application Tool
Application Submission
Licensed Producer

June 2016

Introduction

Welcome to the Kaiser Permanente Apply Online Tool.

Submitting applications for off exchange, small group coverage in Maryland and Virginia just got easier.

Kaiser Permanente's Apply Online secure website will allow employers and producers to quickly and easily apply online for off exchange, small group coverage in Maryland or Virginia. You'll have access to tools to help you view plans, enroll employees and dependents, pay your first month's premium and monitor the application progress.

A few tips to help you get started:

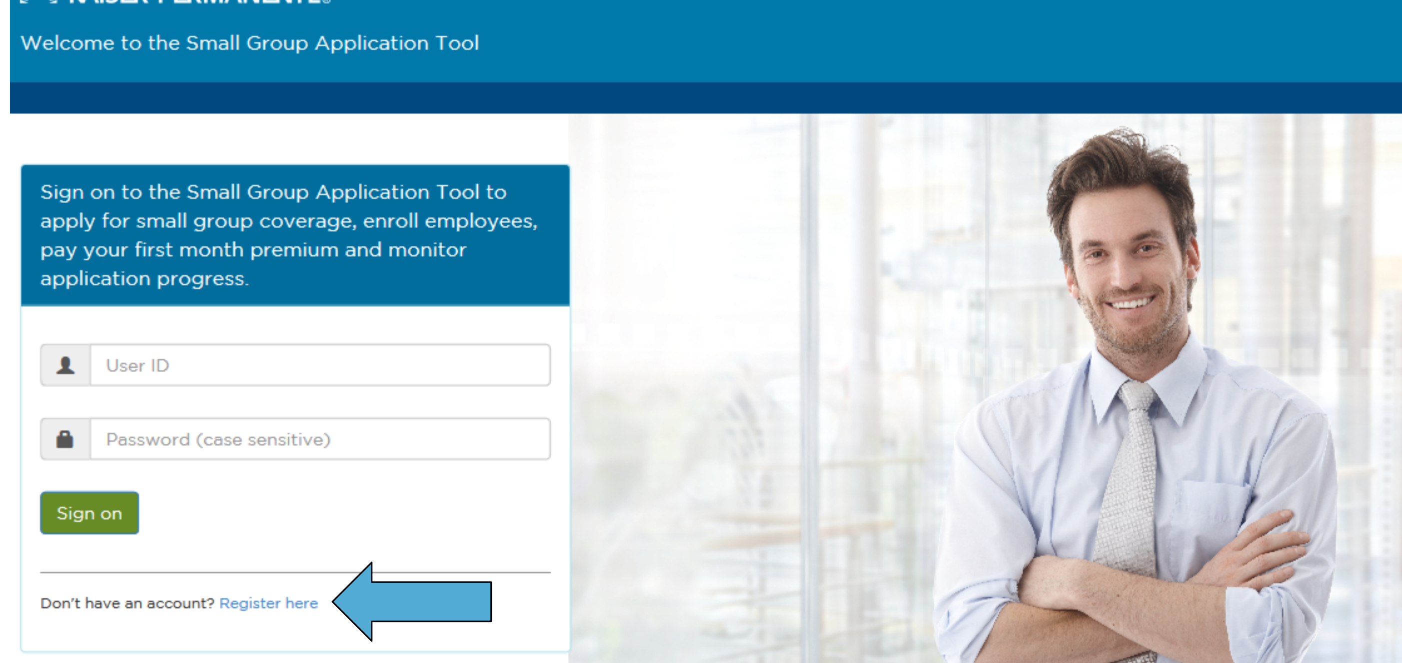
If you are an employer working with a broker, please be sure that your broker submits your application online.

To enhance your user experience, please ensure you are using the most updated browser version.

If you experience any difficulties, please call us at 855-462-3400 Monday through Friday 9 a.m. to 5 p.m. Eastern time or Email us at onlineenrollment@onlinekp.com.

CONFIDENTIAL

Getting Started - New User Registration



The first step in using the small group online application tool is registering as a new user.

1. To start, go to your browser and enter https://midatlanticapplicationtool.kp.org
2. Click the "**Register Here**" link to establish a Licensed Producer account.

(Continued on next page)

Getting Started - New User Registration

Register

Sign On

*Required

Email* [Email Address]

**Email will be used as User Name for Login

First Name* [First Name]

Last Name* [Last Name]

Phone #* [(___)___-____]

Register as* ◉ Licensed Producer ○ Employer

Firm Name* [Firm Name]

National Producer Number* [NPN]

Kaiser Permanente Agent ID [Kaiser Permanente Agent ID]

Password* [Password]

Confirm Password* [Confirm Password]

Sign Up

Licensed Producers will be required to provide:

- Email address – this will also be the User ID.
- First and Last Name
- Phone number
- Firm name
- National Producer Number
- Kaiser Permanente Agent ID – if available

To complete the registration process, please enter a unique password that you will remember. Password must:

- Contain at least one number
- Contain at least one uppercase and lowercase letter
- Be at least 6 characters long
- Not contain symbols

Once the required fields have been provided, click on **Sign Up** to complete the registration process.

(Continued on next page)

CONFIDENTIAL

Getting Started – New User Registration

Kaiser Permanente

""All producers must be appointed with Kaiser Permanente within 30 days of the sale. Our records show that you are not currently appointed with Kaiser Permanente. Please contact the Broker Support Service Center from 9 a.m. to 9 p.m. Eastern time at 844-268-2943 to become appointed with Kaiser Permanente within 30 days of the sale.""

Cancel | Continue

The system will determine if the user is appointed with Kaiser.

If not appointed with Kaiser and National Producer Number was provided, a pop up message will display.

To proceed, click on **Continue**.

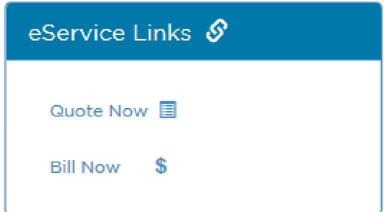
This will allow you to move forward with the online application submission process.

Home Page – How to Navigate

Home | Apply Online | Check Application Status | Plans and Products | Reports | Resources

Welcome to the Small Group Application Tool

Welcome: Darby Doe



Quick Links

Kaiser Permanente Brokernet
Access import producer notification and information

Kaiser Permanente Selling Plans
Plan details and quoting for all employer sizes

Kaiser Permanente Your Clients
Secure access to your existing Kaiser Permanente book of business. Separate login required.

Kaiser Permanente Working With Us
Information on partnering with Kaiser Permanente including the broker code of conduct and commission details

Kaiser Permanente Resource Library
Printable forms, Kaiser Permanente contact information, and sales materials.

After successfully registering, you will be presented with a navigation toolbar, which is divided into three sections:

Top Menu Toolbar

Apply Online	Start the online application process.
Check Application Status	Displays a list of applications in progress and/or submitted.
Plans and Products	Provides the 2016 Plan Summary for MD and VA.
Reports	Broker specific reports
Resources	MD and VA Small Group Business Guide for 2016

eService Links

- Quote Now
- Bill Now

Quick Links

- Kaiser Permanente Brokernet
- Kaiser Permanente Selling Plans,
- Kaiser Permanente Your Clients
- Kaiser Permanente Working with Us
- Kaiser Permanente Resource Library

CONFIDENTIAL

Home Page – Welcome Message

Welcome to the Small Group Application Tool

Home | Apply Online ▾ | Check Application Status | Plans and Products ▾ | Reports ▾ | Resources ▾

Welcome: Darby Doe

Logout

eService Links

- Quote Now
- Bill Now $

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Have Questions?

Contact Customer Service Center at 855-462-3400 Monday through Friday from 9 a.m. to 5 p.m. Eastern time or Email: onlineenrollment@onlinekp.com

The steps required are outlined in the **Welcome Message**.

Step 4 allows the user to upload an enrollment form or data enter the group enrollment manually.

Download the **Enrollment Form** if you prefer to upload the group membership by spreadsheet.

The **Enrollment Form** can be downloaded from this screen or later in the application process.

Welcome to the Small Group Application Tool

The Small Group Application Tool will allow you to apply for off-exchange small group coverage in Maryland and Virginia. Applicants wishing to apply for small group DC coverage should visit the DC HealthLink dchealthlink.com/smallbusiness.

The tool guides users through the application process using the following steps.

Step 1: Complete the Application

Step 2: Upload Supporting Documentation

- Quote results showing selected plans
- Quarterly Wage and Tax Statement (QWTS) for groups enrolling 5 or fewer Full-Time/Full-Time Equivalent employees
- Current pay stubs for employees not shown on the Quarterly Wage and Tax Statement (QWTS)
- Incapacitated Prospective Member Form (Where applicable for over aged dependents)

Step 4: Enroll Employees & Dependents

**Employees and dependents can be enrolled by completing the required fields within the tool, OR by completing and uploading the Enrollment Form. You may download the Enrollment Form now and complete it so it is ready to upload when you get to step 4.*

Download Enrollment Form - MD | Download Enrollment Form - VA

the Application - Employee Eligibility

- **PLAN NAME:** Only choose a plan that was selected in Step 1. Complete the Application - Rates & Benefit Plan Requested
- **EMPLOYEE SSN:** Enter 000-00-0000 if you do not know the employee SSN. Be sure to complete the employee SSN when adding a dependent
- **DEPENDENT SSN:** Enter 000-00-0000 if you do not know the dependent SSN

Step 5: Provide Binder Payment information

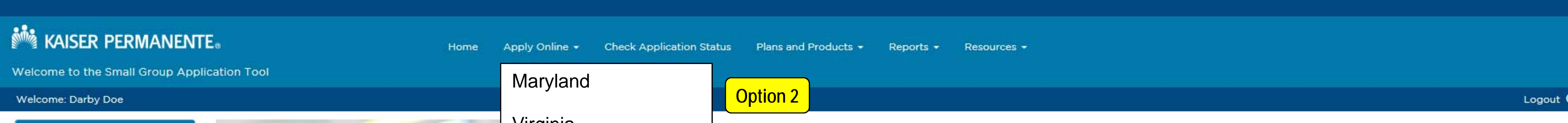
Step 6: Review the Application & Submit to Employer for Signature

Our Small Group Service Center will review your application and provide feedback throughout the approval process. You can return to the tool at any time to see the status of your application(s) and to update your submission(s) as requested.

As you proceed through the application process, be sure to select the "Next" button at the bottom of each section to save your work. Application sections that are partially completed will not be saved.

Start Here for Maryland Coverage | Start Here for Virginia Coverage

To Start an Application



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The tool guides users through the application process using the following steps.

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- Current pay stubs for employees not shown on the Quarterly Wage and Tax Statement (QWTS)
- Incapacitated Prospective Member Form (Where applicable for over aged dependents)

**While not required to upload, employer must keep completed employee enrollment forms.*
Maryland employee enrollment form is available by clicking here
Virginia employee enrollment form is available by clicking here

Step 3: Review the Employer Agreement

Step 4: Enroll Employees & Dependents
**Employees and dependents can be enrolled by completing the required fields within the tool, OR by completing and uploading the Enrollment Form. You may download the Enrollment Form now and complete it so it is ready to upload when you get to step 4.*

Download Enrollment Form - MD   Download Enrollment Form - VA

TIPS FOR SUCCESSFULLY COMPLETING THE ENROLLMENT FORM

- Items in: RED are required, BLACK are optional, ORANGE should be completed based on the instruction boxes that will guide you as you complete the form.
- **WORK LOCATION:** Enter the Work Location exactly as entered in Step 1. Complete the Application - Employee Eligibility
- **PLAN NAME:** Only choose a plan that was selected in Step 1. Complete the Application - Rates & Benefit Plan Requested
- **EMPLOYEE SSN:** Enter 000-00-0000 if you do not know the employee SSN. Be sure to complete the employee SSN when adding a dependent
- **DEPENDENT SSN:** Enter 000-00-0000 if you do not know the dependent SSN

Step 5: Provide Binder Payment information

Step 6: Review the Application & Submit to Employer for Signature

Our Small Group Service Center will review your application and provide feedback throughout the approval process. You can return to the tool at any time to see the status of your application(s) and to update your submission(s) as requested.

As you proceed through the application process, be sure to select the "Next" button at the bottom of each section to save your work. Application sections that are partially completed will not be saved.

Start Here for Maryland Coverage   Start Here for Virginia Coverage   Option 1

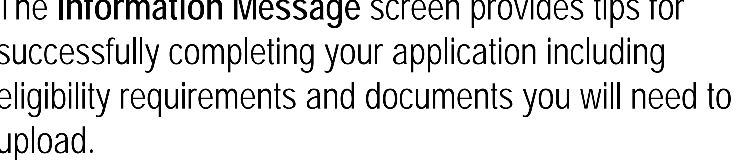
Have Questions?

Contact Customer Service Center at 855-462-3400 Monday through Friday from 9 a.m. to 5 p.m. Eastern time or Email: onlineenrollment@onlinekp.com

To start an application:

Option 1 - After reviewing the **Welcome Message** by selecting the jurisdiction based on the location of your client.

Option 2 - By selecting **Apply Online** from the top navigation toolbar. Select MD or VA based on where your client is located.



The **Information Message** screen provides tips for successfully completing your application including eligibility requirements and documents you will need to upload.

Please keep all completed employee enrollment forms. It is not necessary to upload employee enrollment forms in the Apply Online tool.

Quick Navigate

Information Message ▾

INFORMATION MESSAGE

Virginia Small Group Employer Application
Required Information and Supporting Documents
Tips for successfully completing your Virginia small business application

You are beginning the small business application process for off-exchange business. To apply for SHOP coverage visit your states' marketplace.

1. Small Business eligibility requirements include:
   - Virginia Employer has no more than 50 FTEs.
   - Employees must work a minimum of 30 hours per week on a full time basis. Employers in Virginia have the option to cover part time employees who work 20 hours per week.
   - The employer may not exclude classes of employees other than union employees covered under a Taft-Hartley contract.
   - The employer does not currently offer small group Kaiser Permanente coverage.
   - Defining Employer Contribution Requirments:
     - In accordance with Virginia law, a small group is required to contribute a minimum of 50% towards the total premium cost of the employee-only premium or 50% of the total cost of the employee only premium for the lowest priced product option sponsored by employer group.
     - For non-contributory groups - 100% participation is required of all eligible employees.
     - For contributory groups - 70% participation of eligible employees required.

2. Documentation required for electronic upload:
   - Quote results showing selected plans
   - Quarterly Wage and Tax Statement (QWTS) for groups enrolling 5 or fewer Full-Time/Full-Time Equivalent employees
   - Current pay stubs for employees not shown on the Quarterly Wage and Tax Statement (QWTS)
   - Incapacitated Prospective Member Form (Where applicable for over aged dependents)

     **While not required to upload, employer must keep completed employee enrollment forms.*

     Virginia employee enrollment form is available by clicking here

Next

Step 1. Complete the Application – Applicant's Information

STEP 1. COMPLETE THE APPLICATION

APPLICANT'S INFORMATION

*Required

Legal Business Name *

Legal Business Name

D/B/A (if applicable)

DBA

Legal Status *

- Partnership
- Corporation
- LLC
- Sole Proprietor
- Other

Street Address *

Street Address

Street Address 2

Street Address 2

City *

City

State *

Select State...

Zip Code *

99999

Executive Contact Person *

Executive Contact Person

Title *

Title

Phone *

(___)___-____

Fax

(___)___-____

Email address *

Email address

Type of Business *

Type of Business

SIC/NAICS Code

SIC/NAICS Code

Federal Tax ID Number *

__-_______

Requested Effective Date *

Applications must be submitted no later than 3 business days after the requested effective date.
You can select the 1st or the 15th of the month as your effective date.

--Select Requested Effective Date--

Inception Date of Company Operation *

__/__/____

Business License Number

Business License Number

Do you have workers' compensation co

- Yes
- No

Are there any affiliates or subsidiaries to be covered? *

- Yes
- No

Previous Next

To complete the **Applicant's Information** section, all fields that are identified with a red asterisk (*) next to the field name must be completed.

For **Requested Effective Date**, please note application must be submitted no later than 3 business days after the requested effective date. You can select the 1st or the 15th of the month as the effective date and it cannot be more than 60 days past the current date. **See Figure 1.**

Missing required fields will be identified by highlighting the field in red. **See Figure 2.**

Requested Effective Date *

Applications must be submitted no later than 3 business days after the requested effective date.
You can select the 1st or the 15th of the month as your effective date.

--Select Requested Effective Date--

Figure 1

Street Address *

Street Address

City *

Baltimore

State *

Maryland

Figure 2

Step 1. Complete the Application – Billing Information

STEP 1. COMPLETE THE APPLICATION

BILLING INFORMATION

*Required

Same as applicant information? *

- (selected) Yes
- No

If yes, skip to the next section.

If **Billing Contact** is the same as the applicant information by selecting **Yes**, the system will auto populate the fields.

Should the Billing Contact be different, select **No** and all required fields must be completed.

Click **Next** to advance to the next section.

Field	Value
Billing Address 1 *	7800 Atlantic Avenue
Billing Address 2	Billing Address 2
City *	Virginia Beach
State *	Virginia
Zip Code *	34599
Billing Contact Person *	Joe Smith
Title *	Owner
Phone *	(703)555-1212
Fax	(___)___-____

Previous | Next

Step 1. Complete the Application – Rates and Benefit Plan Requested

STEP 1. COMPLETE THE APPLICATION

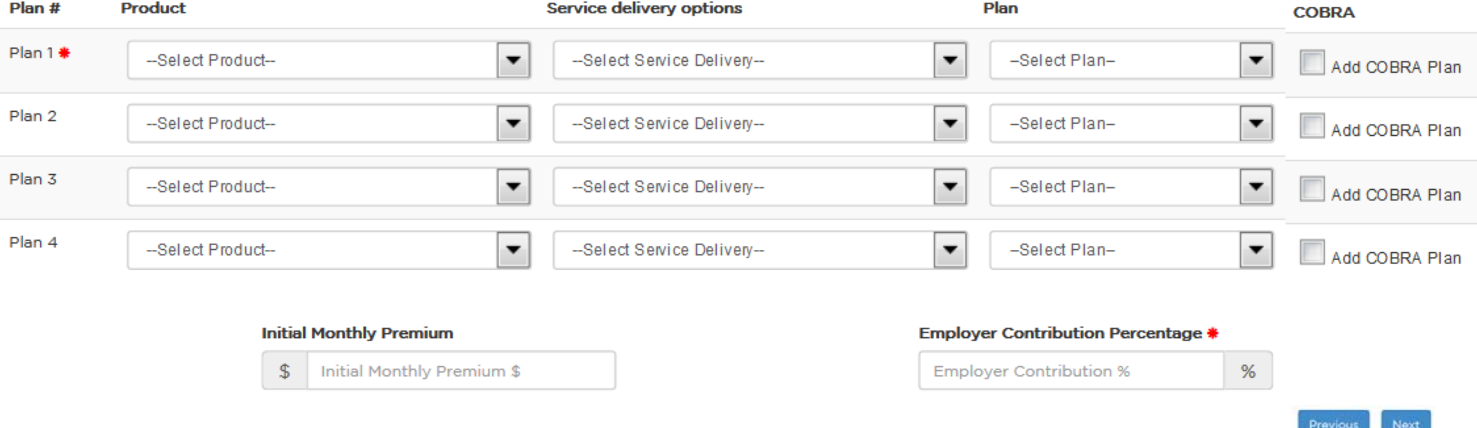
RATES AND BENEFIT PLAN REQUESTED

Choose your Small Group Health Plan(s) which includes pediatric dental essential health benefits and adult preventive and discounted dental benefits. HMO, Dedu Choice POS, and Flexible Choice (Tier 1 - HMO) benefits are underwritten by KFHP-MAS. Flexible Choice (Tier 2 - PPO & Tier 3 - Out-of-network) benefits are und certain HDHP plans the employer is required to open and contribute to HSA or HRA accounts for employees, as described in section 8. **Groups may select up to f**

NOTE: Flexible Choice POS is Signature Service Delivery only.

*Required

MEDICAL



Plan #	Product	Service delivery options	Plan	COBRA
Plan 1 *	--Select Product--	--Select Service Delivery--	--Select Plan--	Add COBRA Plan
Plan 2	--Select Product--	--Select Service Delivery--	--Select Plan--	Add COBRA Plan
Plan 3	--Select Product--	--Select Service Delivery--	--Select Plan--	Add COBRA Plan
Plan 4	--Select Product--	--Select Service Delivery--	--Select Plan--	Add COBRA Plan

Initial Monthly Premium

$ Initial Monthly Premium $

Employer Contribution Percentage *

Employer Contribution % %

Previous Next

A minimum of one product with associated service delivery and plan options must be selected with no more than a maximum of four products.

Start by selecting the following from the drop down menus provided:

- Product
- Service Delivery Option
- Plan

If the Group would like to enroll Employees and their Dependents in Cobra, please ensure the box **Add Cobra Plan** is selected.

Click **Next** to advance to the next section.

Optional MD Only

DENTAL ENHANCEMENTS (OPTIONAL)

Product

- HMO Adult Dental Rider - age 19 & older
- PPO Adult Dental Rider - age 19 & older
- POS Adult Dental Rider - age 19 & older
- None

Figure 3

Maryland provides a **Dental Enhancement** option for this section.

Please select the **Dental Enhancement** option associated with your product selection. **See Figure 3.**

Step 1. Complete the Application – Employee Eligibility

STEP 1. COMPLETE THE APPLICATION

EMPLOYEE ELIGIBILITY

Please complete the information below for all employees by entering the applicable number of employees by work location. Refer to healthcare.gov or your legal counsel for inf[...] calculating the number of full-time, part-time, full-time equivalent, and eligible employees.

*Required

Number of locations: 3

	Work location (by State/Jurisdiction) *	Full-time/ Owner *	Full-time equivalent employees *	Eligible employees *	COBRA *
		Number of employees			
01	Location 001	5	20	10	0
02	Location 002	2	5	5	0
03	Location 003	0	2	2	0
	Total:	7	27	17	0

I attest that my company will offer group health coverage to all (check one): *

- Part-time employees and full-time employees
- Only full-time employees

Will coverage be provided to domestic partners? *

- Yes
- No

How many employees are waiving coverage? *

0

Previous Next

Determine how many locations are required. If more than one location, select the **"Number of Locations"** from the drop down. You can select up to a maximum of 20 locations.

Complete the rows starting with the **Work Location – State/Jurisdiction** and follow by entering the Number of Employee counts.

The **Total** column will automatically adjust.

Complete the remaining questions.

Click **Next** to advance to the next section.

If applying for coverage in Virginia, select **Yes** or **No**.

If **Yes**, you will be required to complete the other carrier's information section.

If **No**, click **Next** to advance to the next section.

STEP 1. COMPLETE THE APPLICATION

OTHER HEALTH CARE COVERAGE INFORMATION

*Required

Are you applying for this insurance to replace current or prior coverage provided by another group health carrier? *

- Yes
- No

If answer Yes, please provide the following information:

Carrier's Name *

Carrier's Name

Effective Date *

__/__/____

Group/Policy Number *

Group/Policy Number

Termination Date *

__/__/____

Previous Next

Step 1. Complete the Application – Broker Information

STEP 1. COMPLETE THE APPLICATION

BROKER INFORMATION

*Required

Field	Value
Broker Name *	Darby Doe
Broker Firm Name *	The Darby Doe Agency
Street Address *	Street Address
City *	City
State *	Select State...
Zip Code *	99999
Phone *	(703)555-1212
Fax	(___)___-____
Email address *	darbydoeagency@gmail.com
Life & health license number *	Life & Health License Number
National Producer Number *	9999
Kaiser Permanente Agent ID	Kaiser Permanente Agent ID
Federal tax ID number *	__-_______
General agent name *	--Select General Agent Name--
Kaiser Permanente Sales Representative *	Select Sales Representative...

Your broker is/may be paid commissions and other financial incentives by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Previous   Next

The system will **auto populate fields** that were provided during the registration process:

- Broker Name
- Broker Firm Name
- Phone
- Email address
- National Producer Number
- Kaiser Permanente Agent ID

To complete this screen, you must provide the remaining required information:

- Street Address
- City
- State
- Zip
- Life & health license number
- Federal Tax ID number
- General agent name
- Kaiser Permanente Sales Representative

Lastly, select your Kaiser Permanente Sales Representative from the drop down list.

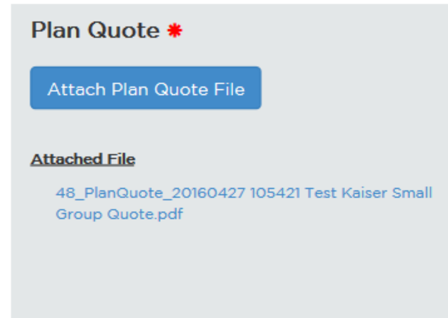
Click **Next** to advance to the next section.

Step 2. Upload Supporting Documentation

STEP 2. UPLOAD SUPPORTING DOCUMENTATION

- Plan Quote is required.
- Most recent Quarterly Wage and Tax Statement (QWTS) is required for groups enrolling 5 or fewer Full-Time, Full-Time equivalent employees. S proprietors, partners and corporate officers not appearing on the QWTS that are applying for coverage must provide an acceptable document a alternative.
- While not required to upload, employer must keep completed employee enrollment/waiver forms.

*Required



Quarterly Wage and Tax Statement

Attach Quarterly Wage and Tax Statement

Attached File

Other Documents

Attach Other Document File

Attached File

Previous Next

Review the instructional wording located under the screen title.

Plan Quote is the only required uploaded document.

- Click **Attach Plan Quote**
- Click **Select File** and select the document to upload.
- Click **Upload**
- Click **Close** when the file has completed the uploading process.

See Figure 4.

Click **Next** to advance to the next section.

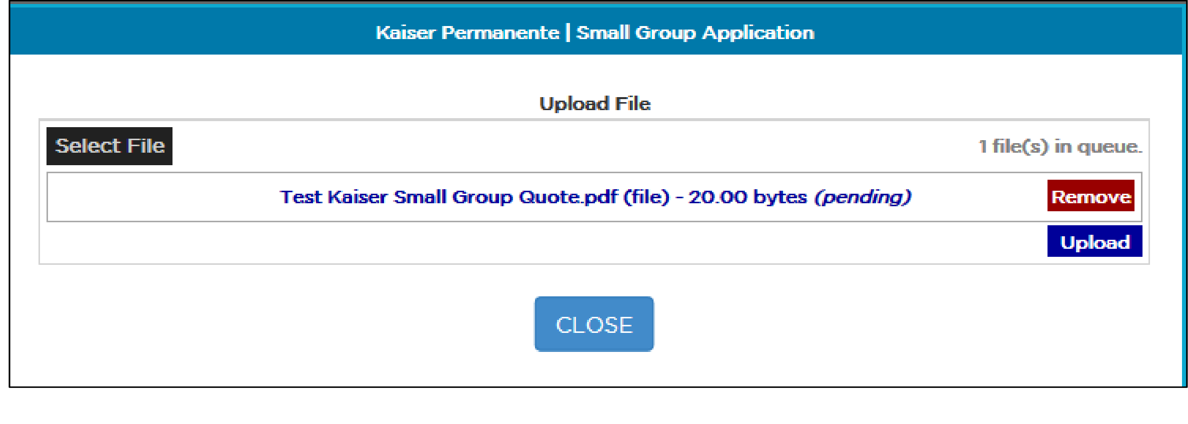


Figure 4

CONFIDENTIAL

Step 3. Review the Employer Agreement

If applying for coverage in **Maryland**:

- Review this section
- Provide optional response

Click **Next** to advance to the next section.

STEP 3. REVIEW THE EMPLOYER AGREEMENT

Section 6: ENROLLMENT INFORMATION

MINIMUM PARTICIPATION REQUIRMENTS

In applying the minimum participation requirement to determine whether the [60%] of participation is met, KFHPMAS/ KPIC may not consi
spousal coverage under a public or private plan of health insurance or another employer's health benefit arrangement, including Medicare, I
similar to or exceeding the benefits provided under the Standard Plan; or employees who are under the age of 26 years who are covered ur

☐ **We are applying for coverage during the period that begins on November 15 and extends through December 15, thus not subject to**

Section 7: EMPLOYER AGREEMENT

THE APPLICANT CERTIFIES that the company has a legitimate business operation, and does not exist for the sole purpose of obtaining health coverage.

THE APPLICANT AGREES that in submitting this application, it is acting for and on behalf of itself and as the agent and representative of its employees and COBRA participants, if applicable. The applicant is not the agent or representative of KFHP-MAS/KPIC for any purpose of this application or any group agreement issued pursuant to this application.

THE APPLICANT AGREES that he/she is answering to the best of his/her knowledge and belief. **§15-1212(b) of the Insurance Article permits cancellation for fraud or intentional misrepresentation of material fact by the small employer**. In that instance, KFHP-MAS/KPIC shall return of any subscription charges actually received by KFHP-MAS/KPIC, less the amount of any benefits paid under the coverage

THE APPLICANT AGREES that the effective date will be determined by KFHP-MAS/KPIC and will be the latest of:

- the date this application is given written approval by KFHP-MAS/KPIC; or
- any requested effective date not prior to the date the applicant signs this agreement and KFHP-MAS/KPIC approves the application; or
- the date KFHP-MAS/KPIC establishes for coverage to begin, in the event that this application is not accompanied by all information needed by KFHP-MAS/KPIC.
- Full first months' payment must be received and KFHP-MAS/KPIC must approve the application in writing before the plan becomes effective.

THE APPLICANT CERTIFIES that, unless KFHP-MAS/KPIC agrees otherwise in writing, all persons to be covered, except dependents and those former members covered under a continuation of benefits, are "eligible employees" of the applicant, or of a subsidiary or affiliate listed within this application. "Eligible employee" means an employee who is offered coverage under a health benefit plan by a small employer. "Eligible employee", at the option of the small employer, may include: (i) only full-time employees; or (ii) full-time employees and part-time employees.

THE APPLICANT AGREES to furnish KFHP-MAS/KPIC all data necessary for the efficient administration of the group coverage for the approved covered employees and dependents, if any.

IT IS UNDERSTOOD AND AGREED that none of KFHP-MAS/KPIC's agents have the authority to:

- modify this application form;
- waive the answer to any question on this application form;
- bind KFHP-MAS/KPIC in any way by giving or receiving any data which is not written on this application form;
- alter or amend the Group plan or plans; or
- bind KFHP-MAS/KPIC by making any promise or representation not contained in this application form.

THE APPLICANT AGREES

- that this application is offered as an inducement for the group coverage applied for;
- that this application will form a part of any contract issued;
- that only the information in this application will bind KFHP-MAS/KPIC;
- that no waiver or charge will bind KFHP-MAS/KPIC unless signed by an executive officer of KFHP-MAS/KPIC; and
- that group coverage will only be provided for persons eligible under the plans issued.

THE APPLICANT AGREES to provide KFHP-MAS, in writing, proof of group and employee eligibility. KFHP-MAS reserves the right to inspect the records of the group in order to verify the eligibility of employees and their dependents. In addition, the group must annually complete and return, in advance of the contract anniversary date, any and all documents requested by KFHP-MAS in order to certify the group as a small employer.

IT IS UNDERSTOOD that KFHP-MAS requires that the employer open and contribute to Health Reimbursement Arrangement (HRA) account for employees who enroll in the KP MD Platinum 1350/10/HSA/HRA/Dental/Ped Dental, and to a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) account for employees who enroll in the KP MD Gold 1500/30 /HSA//HRA/Dental/Ped Dental Plan, or KP MD Silver 2500/30/HSA//HRA/Dental/Ped Dental Plan. The amount of the required contribution is exact for each plan and accounts: $625 for the MD Platinum 1250/10/HRA/Dental/Ped Dental Plan, $600 for the KP MD Gold 1500/30/HSA//HRA/Dental/Ped Dental Plan and $450 for the KP MD Silver 2500/30/HSA//HRA/Dental/Ped Dental Plan.

IT IS UNDERSTOOD that the eligibility data provided by my company to KFHP-MAS will include coverage effective dates for my company's employees in compliance with my company's eligibility rules and the waiting period requirements in the Affordable Care Act and regulations, which require that waiting periods may not exceed 90 days. All full time and part-time employees, if the employer elects to offer part-time employees coverage, are considered eligible employees on the effective date.

Previous | Next

Step 3. Review the Employer Agreement

STEP 3. REVIEW THE EMPLOYER AGREEMENT

*Required

The employer agrees to the following eligbility requirements:

Response Required

1. The a[...]mployees.
2. To meet the following **minimum participation requirement:***
   - If the plan is non-contributory, then 100% of the net eligible employees must be enrolled
   - If the plan is contributory, then 70% of the net eligible employees must be enrolled. [Net eligible employees = Total eligible employees less employees with other health coverage]
   - We are applying for coverage during the period that begins on Novemeber 15 and extends through December 15, thus not subject to a minimum participating requirement.
3. The applicant agrees that, unless KFHP-MAS/KPIC agrees otherwise in writing, all persons to be covered, except retirees, dependents and those former employees covered under a continuation of benefits, are "Eligible Employees" of the applicant, or a subsidiary or affiliate listed within this application. "Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee. At the employer's sole discretion, the eligibility criterion may be broadened to include part-time employees." "Employee" as the meaning given such term under section 3(6) or the Employee Retirement Income Security Act of 1974 (29 U.S.C. §1002(6)). Independent contractors/1099 employees are not eligible for coverage.
4. Business certification
   We certify that our company has a legitimate business operation, and does not exist for the sole purpose of obtaining health care coverage.
5. The applicant agrees that in submitting this application, it is acting for and on behalf of itself and as the agent and representative of its employees and COBRA participants, if applicable. The applicant is not the agent or representative of KFHP-MAS/KPIC for any purpose of this application or any group agreement that is issued pursuant to this application, except enrollment.
6. The applicant agrees to offer enrollment in the KFHP-MAS/KPIC products to all individuals entitled to coverage on conditions no less favorable than those for any other health care plan available through the group.
7. The applicant agrees that a bona fide employer/employee relationship exists with respect to each subscriber to be enrolled in the KFHP-MAS/KPIC products. This requirement does not apply to eligible Taft-Hartley trusts and partnerships.
8. The applicant agrees that it assumes responsibility for, and all liability related to, its determinations regarding the eligibility status of each eligible employee and his/her dependents, and understands that KFHP-MAS/KPIC will rely on such eligibility determinations in effectuating coverage. Furthermore, the applicant agrees it will be financially liable to KFHPMAS/KPIC for any errors and/or omissions.
9. The applicant agrees that as required by state law, employer group has a worker's compensation coverage for its employees.*
   - The group carries workers' compensation insurance.
   - The group does[...]ompensation insurance.

   Optional

   If your company[...]rkers' compensation coverage, please explain.
10. The applicant agrees to hold an open enrollment period 30 days prior to the group's contract renewal date, during which all individuals entitled to coverage are offered a choice of enrollment in the KFHP-MAS/KPIC products.
11. The applicant agrees that the group coverage applied for in this application will not become effective until:
    a. This application is approved by KFHP-MAS/KPIC
    b. An advance payment equal to an estimated one-month premium is received by KFHP-MAS/KPIC and
    c. That if the cost of the coverage is to be contributory, the required percentage of the eligible employees shall have agreed to make the required contribution.
12. The applicant agrees that the agent or the broker do not have the power on behalf of KFHP-MAS/KPIC, to make or modify any application for coverage, to make any promise or representation, or to waive any of the companies' (KFHP-MAS/KPIC) rights or requirements.
13. It is understood that KFHP-MAS requires that the employer open and contribute to Health Reimbursement Arrangement (HRA) account for employees who enroll in the KP VA Platinum 1350/10/HSA/HRA/Dental/Ped Dental, and to a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) account for employees who enroll in the KP VA Gold 1500/30/HSA/HRA/Dental/Ped Dental Plan, or KP VA Silver 2500/30/HSA//HRA/Dental/Ped Dental Plan. The amount of the required contribution is exact for each plan and accounts: $625 for the VA Platinum 1350/10/HRA/Dental/Ped Dental Plan, $600 for the KP VA Gold 1500/30/HSA/HRA/Dental/Ped Dental Plan and $450 for the KP VA Silver 2500/30/HSA//HRA/Dental/Ped Dental Plan.
14. The Applicant attests that the company does meet the definition of "small employer" as defined by applicable federal and state law. By signing this application, the applicant acknowledges that this attestation may be subject to verification and agrees to provide KFHP-MAS with any information necessary to do so.
15. The eligibility data provided by my company to KFHP-MAS will include coverage effective dates for my company's employees in compliance with my company's eligibility rules and the waiting period requirements in the Patient Protection and Affordable Care Act and regulations, which require that waiting periods may not exceed 90 days. All full time and part-time employees, if the employer elects to offer part-time employees coverage, are considered eligible employees on the effective date.
16. **WARNING: IT IS a crime to provide false or misleading information to an insurer for the purpose of defrauding and/or misleading the insurer or any other person. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.**

Previous | Next

If applying for coverage in **Virginia:**

- Review this section
- Provide required and optional response

Click **Next** to advance to the next section.

CONFIDENTIAL

Step 4. Enroll Employees and Dependents

Option 1: Enroll Employees and Dependents - Upload Enrollment Form

Enrollment Form

TIPS FOR SUCCESSFULLY COMPLETING THE ENROLLMENT FORM

- Items in: RED are required, **BLACK** are optional, ORANGE should be completed based on the instruction boxes that will guide you as you complete the form.
- **WORK LOCATION:** Enter the Work Location exactly as entered in Step 1. Complete the Application - Employee Eligibility
- **PLAN NAME:** Only choose a plan that was selected in Step 1. Complete the Application - Rates & Benefit Plan Requested
- **EMPLOYEE SSN:** Enter 000-00-0000 if you do not know the employee SSN. Be sure to complete the employee SSN when adding a dependent
- **DEPENDENT SSN:** Enter 000-00-0000 if you do not know the dependent SSN

Download Enrollment Form - VA

You may use the downloadable **Enrollment Form** to provide information about your employees and dependents that will be applying and/or waiving group health coverage.

To ensure we capture this information accurately, please only use the Enrollment Form provided, which can be downloaded from this screen.

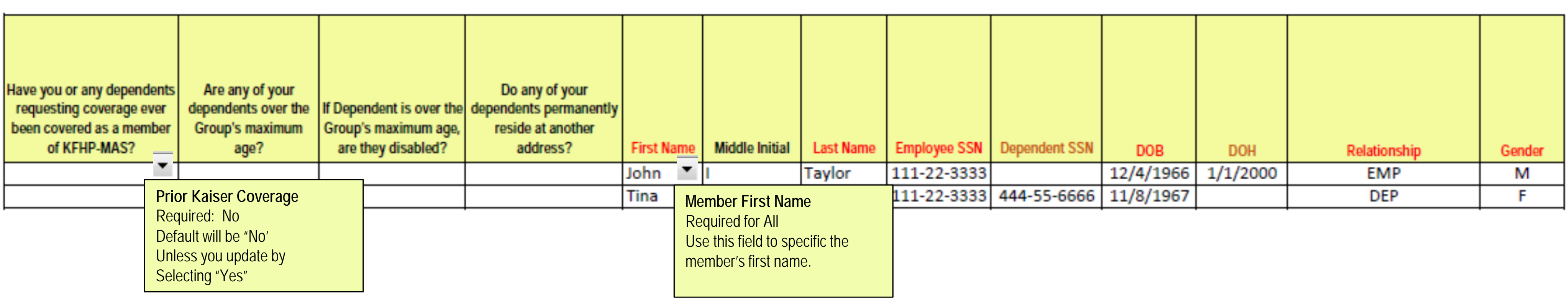
There is a separate enrollment form for each jurisdiction.

If your group resides in Maryland, you should be completing the Maryland application. The system will provide the **Enrollment Form – MD**.

If your group resides in Virginia, you should be completing the Virginia application. The system will provide the **Enrollment Form – VA**

(Continued on next page)

Step 4. Enroll Employees and Dependents



Have you or any dependents requesting coverage ever been covered as a member of KFHP-MAS?	Are any of your dependents over the Group's maximum age?	If Dependent is over the Group's maximum age, are they disabled?	Do any of your dependents permanently reside at another address?	First Name	Middle Initial	Last Name	Employee SSN	Dependent SSN	DOB	DOH	Relationship	Gender
				John	I	Taylor	111-22-3333		12/4/1966	1/1/2000	EMP	M
				Tina			111-22-3333	444-55-6666	11/8/1967		DEP	F

Prior Kaiser Coverage
Required: No
Default will be "No'
Unless you update by
Selecting "Yes"

Member First Name
Required for All
Use this field to specific the
member's first name.

Once the Enrollment Form has ben downloaded, proceed by completing the form for all eligible employees by following the **hover help instructions** provided within the form.

Note: Hover Help instructions are available on each field to assist in guiding through the process.

Upon completion of the Enrollment Form, upload the form.

(Continued on next page)

Step 4. Enroll Employees and Dependents

Option 1: Enroll Employees and Dependents - Upload Enrollment Form

Enrollment Form

TIPS FOR SUCCESSFULLY COMPLETING THE ENROLLMENT FORM

- Items in: RED are required, **BLACK** are optional, ORANGE should be completed based on the instruction boxes that will guide you as you complete the form.
- **WORK LOCATION:** Enter the Work Location exactly as entered in Step 1. Complete the Application - Employee Eligibility
- **PLAN NAME:** Only choose a plan that was selected in Step 1. Complete the Application - Rates & Benefit Plan Requested
- **EMPLOYEE SSN:** Enter 000-00-0000 if you do not know the employee SSN. Be sure to complete the employee SSN when adding a dependent
- **DEPENDENT SSN:** Enter 000-00-0000 if you do not know the dependent SSN

Download Enrollment Form - VA

Upload Enrollment Form

To upload the completed **Enrollment Form:**

- Click **Upload Enrollment Form** button
- Click **Select File** and select the document to upload
- Click **Upload**
- Click **Close** when the file has completed the uploading process

Click **Next** to advance to the next section.

(Continued on next page)

Step 4. Enroll Employees and Dependents

Option 1: Enroll Employees and Dependents - Upload Enrollment Form

Enrollment Form

TIPS FOR SUCCESSFULLY COMPLETING THE ENROLLMENT FORM

- Items in: **RED** are required, **BLACK** are optional, **ORANGE** should be completed based on the instruction boxes that will guide you as you complete the form.
- **WORK LOCATION:** Enter the Work Location exactly as entered in Step 1. Complete the Application - Employee Eligibility
- **PLAN NAME:** Only choose a plan that was selected in Step 1. Complete the Application - Rates & Benefit Plan Requested
- **EMPLOYEE SSN:** Enter 000-00-0000 if you do not know the employee SSN. Be sure to complete the employee SSN when adding a dependent
- **DEPENDENT SSN:** Enter 000-00-0000 if you do not know the dependent SSN

Download Enrollment Form - VA

Upload Enrollment Form

Group Enrollment Census File PASSED validations. Please

Existing Form

1_EnrollmentForm_20160427 143256 009 Enrollment V

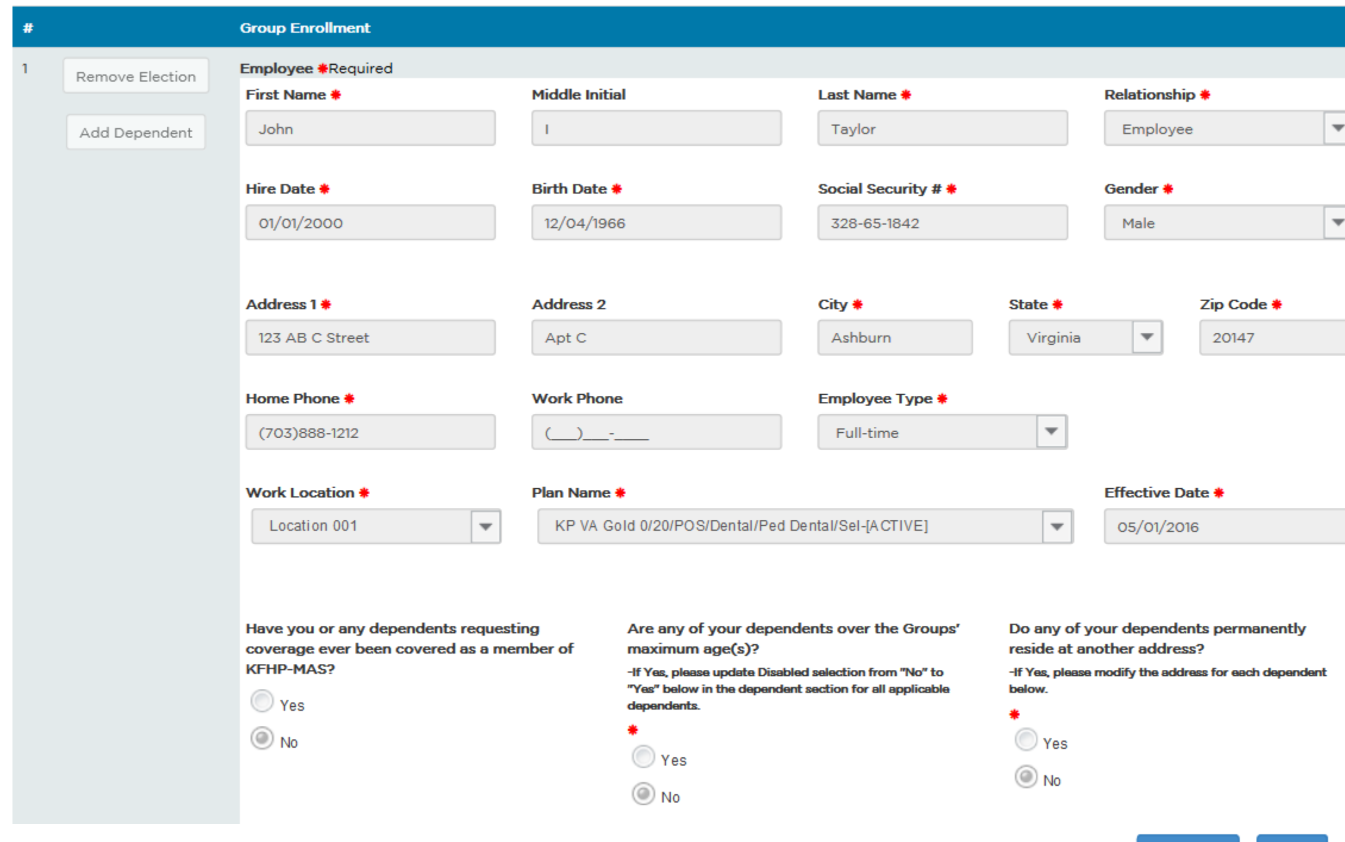
The system will display **PASSED** if the Enrollment Form was uploaded successfully.

To review the most current version of the uploaded Enrollment Form, hover over the document and click to open.

(Continued on next page)

Step 4. Enroll Employees and Dependents

Option 2: Enroll Employees and Dependents - Data Entry



\# Group Enrollment

1 Remove Election | Add Dependent

Employee * Required

First Name *: John
Middle Initial: I
Last Name *: Taylor
Relationship *: Employee

Hire Date *: 01/01/2000
Birth Date *: 12/04/1966
Social Security # *: 328-65-1842
Gender *: Male

Address 1 *: 123 AB C Street
Address 2: Apt C
City *: Ashburn
State *: Virginia
Zip Code *: 20147

Home Phone *: (703)888-1212
Work Phone: (___)___-____
Employee Type *: Full-time

Work Location *: Location 001
Plan Name *: KP VA Gold 0/20/POS/Dental/Ped Dental/Sel-[ACTIVE]
Effective Date *: 05/01/2016

Have you or any dependents requesting coverage ever been covered as a member of KFHP-MAS?
Yes
No

Are any of your dependents over the Groups' maximum age(s)?
-If Yes, please update Disabled selection from "No" to "Yes" below in the dependent section for all applicable dependents.
*
Yes
No

Do any of your dependents permanently reside at another address?
-If Yes, please modify the address for each dependent below.
*
Yes
No

Previous | Next

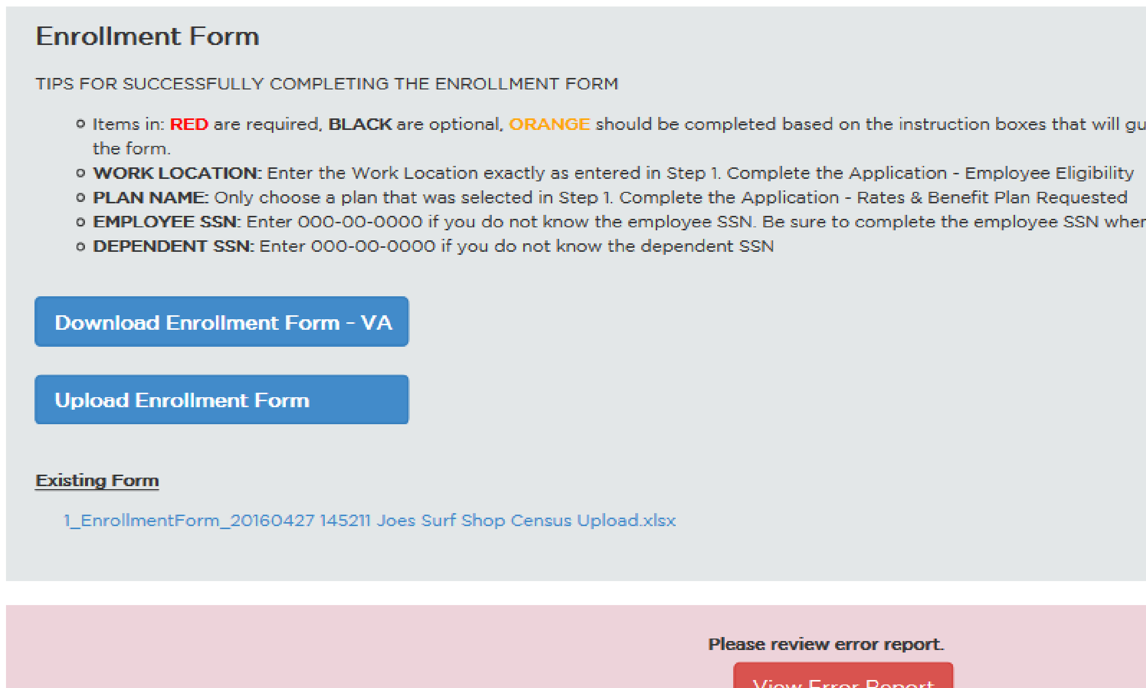
When the Enrollment Form is uploaded successfully, the data provided for each employee on the form will be mapped to the online screen for your review.

If the data is incorrect:

- Update the Enrollment Form
- Resubmit by repeating the uploading process.

If the information is accurate, click **Next** to advance to the next screen.

CONFIDENTIAL



If the **Enrollment Form** did NOT pass the validation process, the system will generate an **error report**.

To view the error report:

- Click **View Error Report**
- Click **OK** to open the Excel spreadsheet. **See Figure 5**.
- Review the **Invalid** message. The error message will explain specifically why the Enrollment Form did not upload properly. **See Figure 6**.
- Update the Enrollment Form
- Resubmit by repeating the uploading process.

If the information is accurate, click **Next** to advance to the next screen.

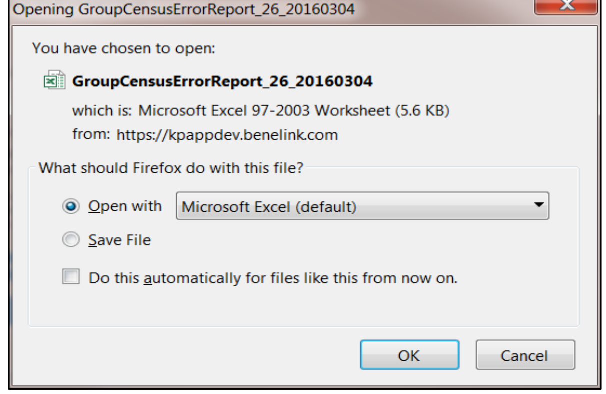


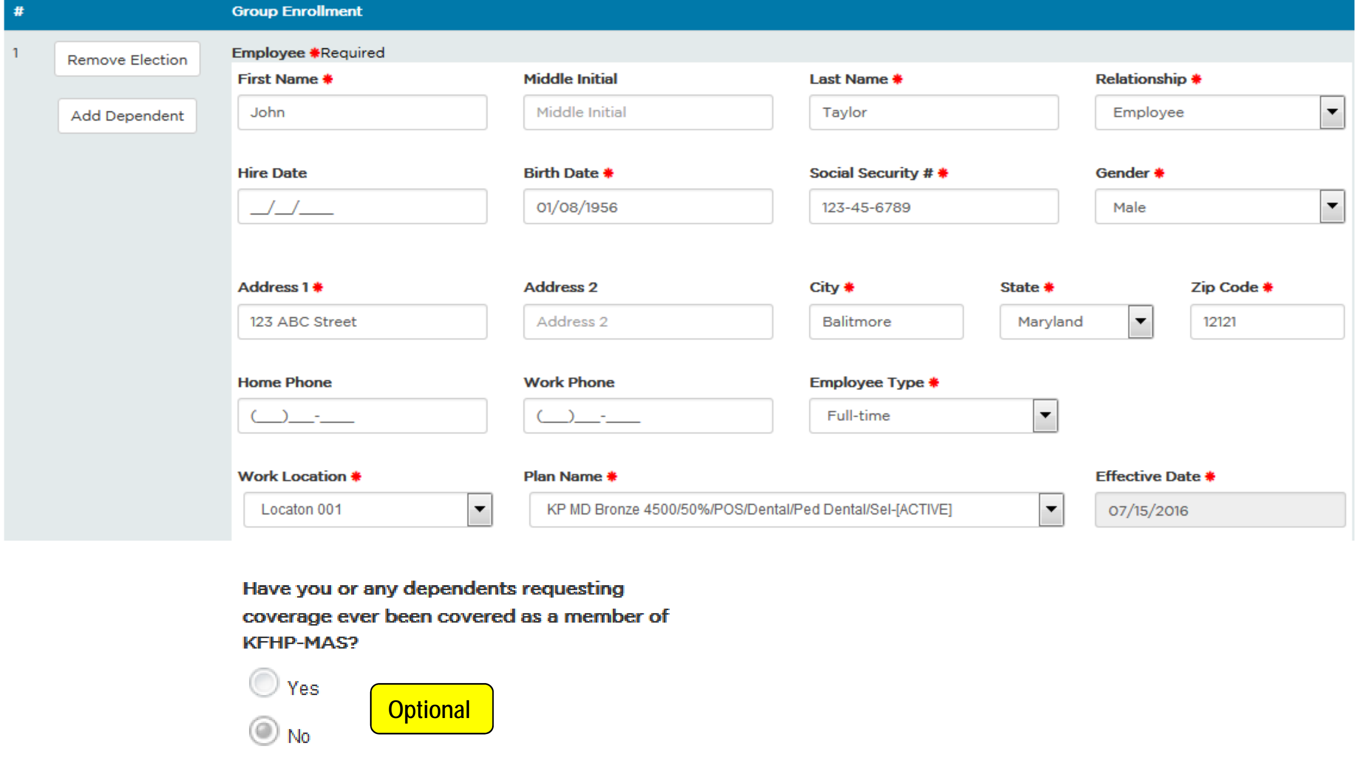
Figure 5

MESSAGE	Waiving Coverage?	If Yes, please select the Waive Refusal type
Record Validated	Yes	All Coverage
Invalid - Plan Name must match the Plan Name selection on the Rates & Benefits screen., Invalid - Location must match exactly as entered on the Employee Eligibility screen.	No	

Figure 6

CONFIDENTIAL

Step 4. Enroll Employees and Dependents



To manually enter the enrollment directly online:

- Enter Employee #1 and complete the required fields.
- The **Work Location** drop down provides a list of the locations that were entered on the Employee Eligibility section.
- The **Plan Name** drop down list will display only the Plan(s) selected on the Rates and Benefits Requested screen.
- **Effective Date** is auto populated based on the Requested Effective Date provided on the Applicant's Information screen.

See **Optional** question.

(Continued on next page)

CONFIDENTIAL

Step 4. Enroll Employees and Dependents

When finished entering the Employee data, if the Employee does not have Dependents:

- Click **Add New Employee**
- Repeat process.

(Continued on next page)

Option 2: Enroll Employees and Dependents - Data Entry

#	Group Enrollment
1	Employee *Required

Remove Election

Add Dependent

First Name *	Middle Initial	Last Name *	Relationship *
John	Middle Initial	Taylor	Employee

Hire Date	Birth Date *	Social Security # *	Gender *
__/__/____	01/08/1956	123-45-6789	Male

Address 1 *	Address 2	City *	State *	Zip Code *
123 ABC Street	Address 2	Balitmore	Maryland	12121

Home Phone	Work Phone	Employee Type *
(___)___-____	(___)___-____	Full-time

Work Location *	Plan Name *	Effective Date *
Locaton 001	KP MD Bronze 4500/50%/POS/Dental/Ped Dental/Sel-[ACTIVE]	07/15/2016

Have you or any dependents requesting coverage ever been covered as a member of KFHP-MAS?

- Yes
- No (selected)

Add New Employee

Step 4. Enroll Employees and Dependents

#	Group Enrollment

1

Remove Election

Add Dependent

Employee * Required

First Name *	Middle Initial	Last Name *	Relationship *
John	Middle Initial	Taylor	Employee

Hire Date	Birth Date *	Social Security # *	Gender *
__/__/____	01/08/1956	123-45-6789	Male

Address 1 *	Address 2	City *	State *	Zip Code *
123 ABC Street	Address 2	Balitmore	Maryland	12121

Home Phone	Work Phone	Employee Type *
(___)___-____	(___)___-____	Full-time

Work Location *	Plan Name *	Effective Date *
Locaton 001	KP MD Bronze 4500/50%/POS/Dental/Ped Dental/Sel-[ACTIVE]	07/15/2016

Required

Have you or any dependents requesting coverage ever been covered as a member of KFHP-MAS?

- Yes
- No

Are any of your dependents over the Groups' maximum age(s)?
-If Yes, please update Disabled selection from "No" to "Yes" below in the dependent section for all applicable dependents.
*

- Yes
- No

Do any of your dependents permanently reside at another address?
-If Yes, please modify the address for each dependent below.
*

- Yes
- No

If the Employee has Dependent(s):

- Click **Add Dependent**.

When **Add Dependent** is selected, the system generates two additional questions at the bottom of the Employee record.

If one or both questions are **Yes**, please follow the instructions outlined under each question.

The Dependent's address will default to the Employee address unless otherwise updated on the Dependent record.

The Plan section and Effective date for the Dependent will also follow what was selected for the Employee.

After you are done with entering all Employee and Dependents, click **Next** to advance to the next section.

CONFIDENTIAL

Step 5. Provide Binder Payment Information

STEP 5. PROVIDE BINDER PAYMENT INFORMATION

Binder payments can be paid by check or electronically online.

- If paying electronically, please complete the Electronic Payment section below. After your application is approved, you will receive an er payment.
- If paying by check, please upload a copy of the check in the amount of your first month's premium and mail the check to: Kaiser Perman Jefferson Street, 5th Floor, Rockville, MD 20852

*Required

Please select one:*

- Electronic Payment
- Binder Check

Select a Payment Option

1) Electronic Payment

First Name * First Name

Last Name * Last Name

Billing Address * Mailing Address

Billing Address 2 Mailing Address 2

City * City

State * Select State...

Billing Zip Code * Billing Zip Code

Amount * $ Amount

2) Binder Check

Attach Binder Check

Previous Next

Binder Payment can be paid electronically or by check.

Option 1

- Click **Electronic Payment** if you would like to pay by credit card.
- Complete the **Electronic Payment**. After your application is approved, you will receive an email with instructions on how to authorize payment.

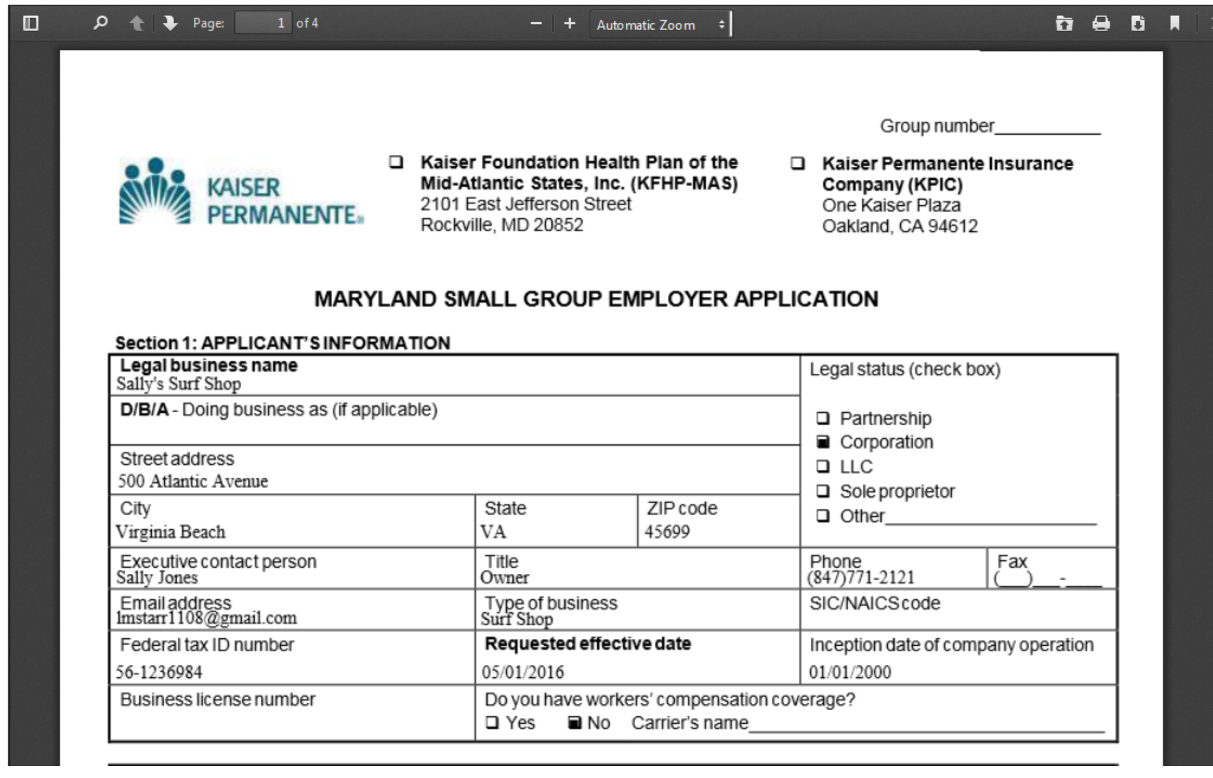
Option 2

- Upload a copy of a **Binder Check**
- Click on **Attach Binder Check**
- Click **Select File** and select the document to upload
- Click **Upload**
- Click **Close** when the file has completed the uploading process.

When finished, click **Next** to advance to the next section.

Review the Application and Submit to Employer for Signature

APPLICATION REVIEW



Group number__________

❑ **Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)**
2101 East Jefferson Street
Rockville, MD 20852

❑ **Kaiser Permanente Insurance Company (KPIC)**
One Kaiser Plaza
Oakland, CA 94612

MARYLAND SMALL GROUP EMPLOYER APPLICATION

Section 1: APPLICANT'S INFORMATION

Legal business name Sally's Surf Shop			Legal status (check box) ❑ Partnership ■ Corporation ❑ LLC ❑ Sole proprietor ❑ Other__________
D/B/A - Doing business as (if applicable)			
Street address 500 Atlantic Avenue			
City Virginia Beach	State VA	ZIP code 45699	
Executive contact person Sally Jones	Title Owner		Phone (847)771-2121 / Fax ( ) -
Email address lmstarr1108@gmail.com	Type of business Surf Shop		SIC/NAICS code
Federal tax ID number 56-1236984	**Requested effective date** 05/01/2016		Inception date of company operation 01/01/2000
Business license number	Do you have workers' compensation coverage? ❑ Yes ■ No Carrier's name__________		

Previous | Submit to Employer for Signature

Licensed Producers applying for coverage must submit the application to the Employer for their review, acknowledgement and digital signature.

Review the populated PDF with the mapped data. If you need to adjust any of your responses, you may do so by clicking on the **Previous** at the bottom of the screen.

- Click **Submit to Employer for Signature**

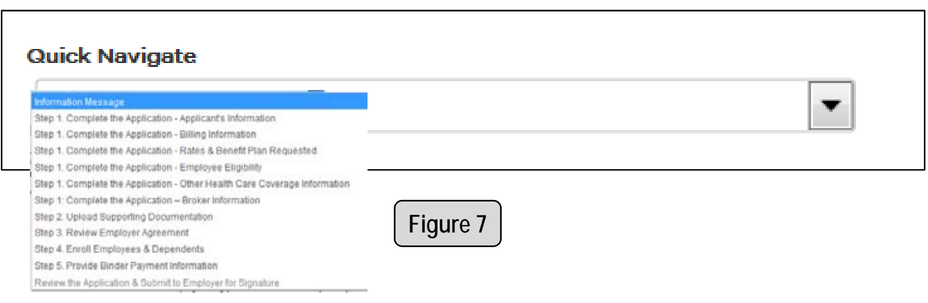
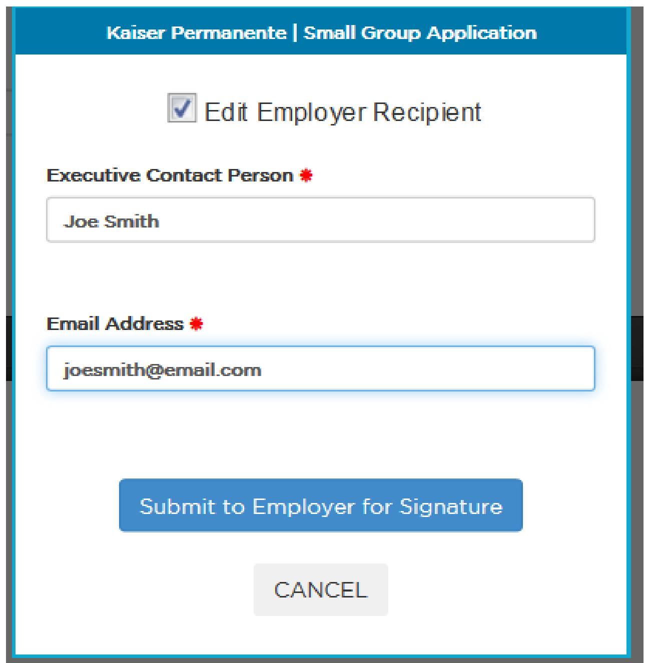


Figure 7

The **Quick Navigation** toolbar at the top of this screen can be used to "quickly" take you back to certain screens. See **Figure 7.**

The PDF also has a toolbar which allows the capability to print or download/save the PDF to your computer.

Submit to Employer for Signature



The system will auto populate the **Executive Contact Person** and **Email Address** based on the information in **Step 1. Complete the Application – Applicant's Information.**

If an alternate Employer Recipient is required, the option to **Edit Employer Recipient** is available.

- Select **Edit Employer Recipient**
- Modify **Executive Contact Person**
- Modify **Email Address**
- Click **Submit to Employer for Signature**

(Continued on next page)

CONFIDENTIAL

Submission Confirmation to Employer

A message confirming the application has been emailed to the **employer for signature** will display including the application number as a reference.

Thank You for your application

This application has been emailed to the employer for signature. You will receive an email when the employer has signed and submitted the application. The application ID number is 1.

You can check the status of the application at any time by using the Small Group Application tool in the Check Application Status section.

If you have any questions concerning the application, contact Small Group Onboarding at MAS-Small-Group-Service-Center@kp.org or your sales representative.

(Continued on next page)

CONFIDENTIAL

Employer – Finalize Submission Request Email

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Joe Smith
Joe's Surf Shop
Owner
123 Main Street
Virginia Beach, VA 23455

04/28/2016

Dear Joe Smith:

An application requesting group health coverage through Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS; Kaiser Permanente), dated 04/28/2016 has been created by Darby Doe. The application ID number is 1.

In order to complete the application submission process, please click here to review the application and provide your digital signature. Once you have done this, please be sure to submit your application.

Once submitted, we will review your application and notify your broker by email within three business days if your application is approved or declined or if we need additional information in order to process your application.

In the meantime, if you have any questions concerning your application, you can contact your broker, Kaiser Permanente sales representative or Small Group Onboarding at MAS-Small-Group-Service-Center@kp.org.

Sincerely,
Small Group Onboarding

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson St., Rockville, MD 20852
60430112 MAS 3/15/16-12/31/17

The **Employer** will receive an email with instructions to finalize the application submission process.

The **Licensed Producer** will also receive a copy of the same email sent to the Employer.

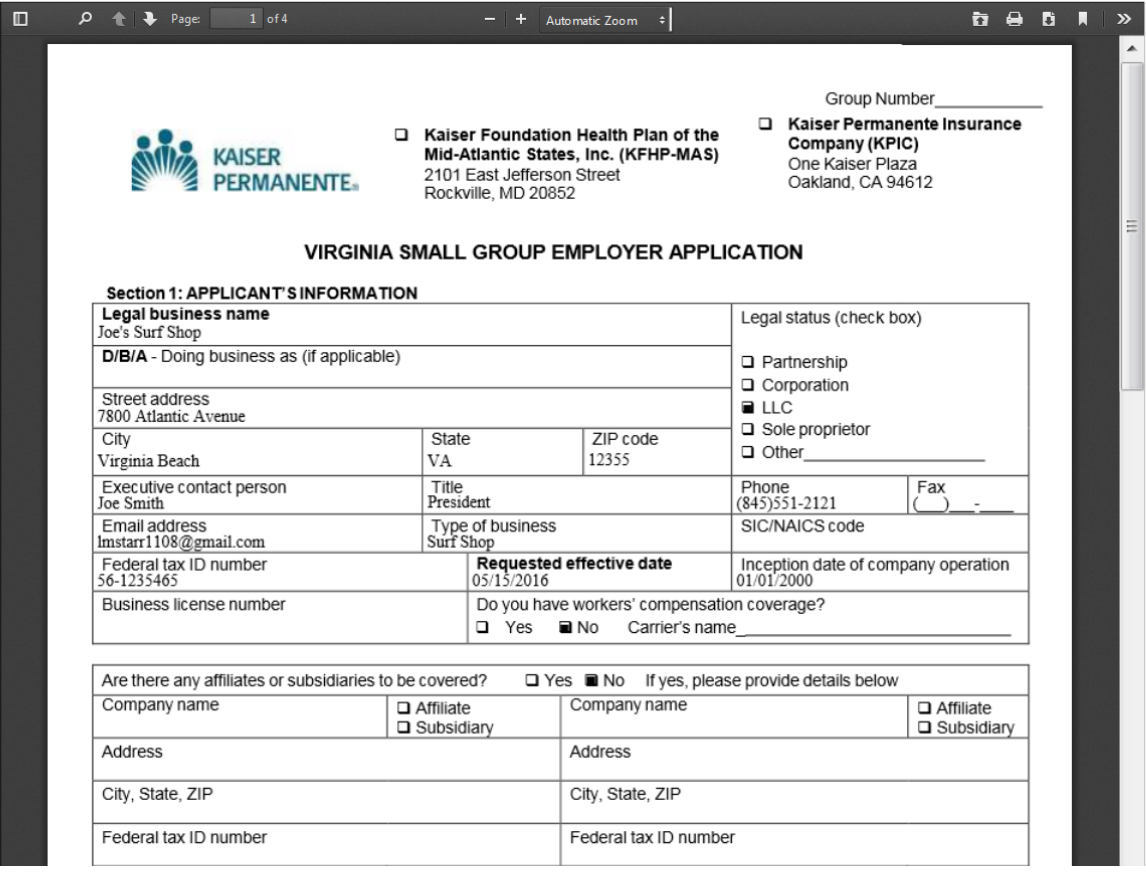
The **Employer** will do the following:

- Click on the link **click here** referenced in the body of the email.

(Continued on next page)

Employer - Review of the Application

APPLICATION REVIEW



Page: 1 of 4 | Automatic Zoom

Group Number___________

KAISER PERMANENTE

❑ **Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)**
2101 East Jefferson Street
Rockville, MD 20852

❑ **Kaiser Permanente Insurance Company (KPIC)**
One Kaiser Plaza
Oakland, CA 94612

VIRGINIA SMALL GROUP EMPLOYER APPLICATION

Section 1: APPLICANT'S INFORMATION

Legal business name Joe's Surf Shop			Legal status (check box) ❑ Partnership ❑ Corporation ■ LLC ❑ Sole proprietor ❑ Other___________	
D/B/A - Doing business as (if applicable)				
Street address 7800 Atlantic Avenue				
City Virginia Beach	State VA	ZIP code 12355		
Executive contact person Joe Smith	Title President		Phone (845)551-2121	Fax ( )___-____
Email address lmstarr1108@gmail.com	Type of business Surf Shop		SIC/NAICS code	
Federal tax ID number 56-1235465	**Requested effective date** 05/15/2016		Inception date of company operation 01/01/2000	
Business license number	Do you have workers' compensation coverage? ❑ Yes ■ No Carrier's name___________			

Are there any affiliates or subsidiaries to be covered? ❑ Yes ■ No If yes, please provide details below

Company name	❑ Affiliate ❑ Subsidiary	Company name	❑ Affiliate ❑ Subsidiary
Address		Address	
City, State, ZIP		City, State, ZIP	
Federal tax ID number		Federal tax ID number	

Next

Employer will review the completed application.

Then click **Next** to advance to the next section.

(Continued on next page)

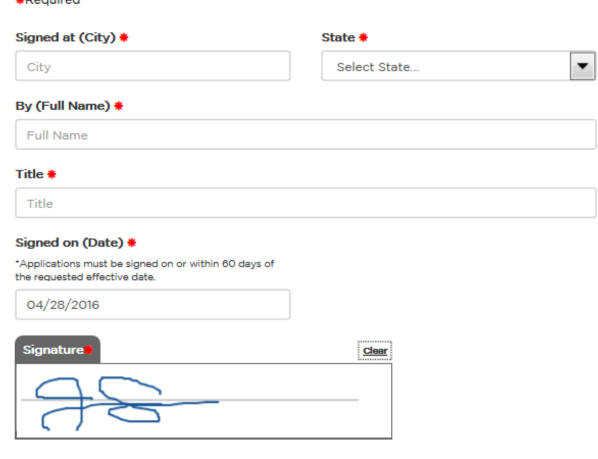
CONFIDENTIAL

Employer – Sign the Application

SIGN THE APPLICATION

I understand and agree, on behalf of the employer, that the statements in this application are true and complete to the best of my knowledge and belief. I understand and agree that such statements and answers; a) will become part of any group agreement which may ultimately be issued by KFHP-MAS/KPIC; and b) are made to induce KFHP-MAS/KPIC to issue the group coverage as applied for. I have the authority to make the statements and representations contained in this application and to execute this application on behalf of the group.

WARNING: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to other actions as allowed by law



The **Employer** enters the following:

- **Signed at (City and State)** – this is the location of the Employer
- **By (Full Name)** – this is First and Last Name of the Employer representative
- **Signed on (Date)** – this is the date that the Employer signs the application.

When finished, the Employer click **Submit.**

(Continued on next page)

Signature options:

- Electronically provide your signature using your computer.

Previous SUBMIT

Employer – Application Submission Confirmation

A message confirming the **Application Submission** will display including the application number as a reference.

Thank You for your application

Your application has been successfully submitted. Your application ID number is 1.

We will review the application and notify your broker by email within three business days if your application is approved or declined or if we need additional information in order to process your application.

If you have any questions concerning the application, contact the Broker you are working with or Kaiser Permanente Small Group Onboarding at MAS-Small-Group-Service-Center@kp.org.

Application Submission Confirmation Email

Joe Smith
Joe's Surf Shop
Owner
123 Main Street
Virginia Beach, VA 23455

04/28/2016

Dear Darby Doe:

Thank you for your interest in Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). Your application requesting group health coverage through KFHP-MAS, dated 04/28/2016 has been successfully submitted. Your application ID number is 1.

We will review your application and notify you by email within three business days if your application is approved or declined or if we need additional information in order to process your application.

Before your group health coverage becomes effective:

1. KFHP-MAS will notify you, in writing, that your application is approved, and
2. Your first month's premium payment must be made in full and received by KFHP-MAS. You can submit your payment by mailing a check, or making an online electronic payment (via credit card or by providing your banking information). If you choose to pay online, we'll send you the instructions on how to do so once your application is approved.

You can check the status of your application at any time by using our Small Group Online Application Tool. Simply sign on to your account at https://midatlanticapplicationtool.kp.org and visit the "Check application status" section.

In the meantime, if you have any questions concerning your application, please contact Small Group Onboarding at MAS-Small-Group-Service-Center@kp.org.

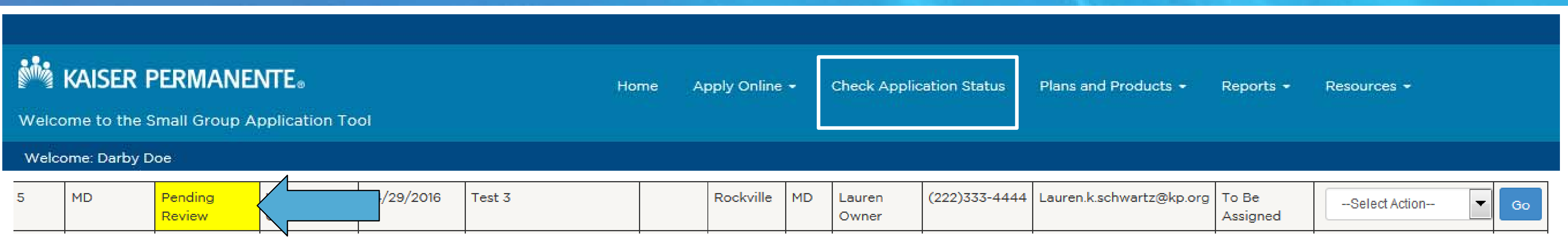
Sincerely,
Small Group Onboarding

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson St., Rockville, MD 20852
60430112 MAS 3/15/16-12/31/17

The **Application Submission Confirmation email** will be sent to:

- Licensed Producer
- General Agent

Check Application Status



Go to the top menu toolbar and click on **Check Application Status.** The application is now in **Pending Review** status.

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Check Application Status

AppID	Jurisdiction	Status	Approver	Submitted Date	Legal Name	DBA	City	State	Contact	Phone	Email	KP SalesRep	Actions	
5	MD	Approved	Ken Gustafson	02/10/2016	LMS MD Broker, Inc.		Baltimore	MD	Lynn Starr	(301)777-1212	lstarr@email.com	To Be Assigned	–Select Action–	Go
21	MD	Pending Info	Ken Gustafson	02/22/2016	Wednesday Test Broker		Baltimore	MD	Broker Smith	(301)777-1212	LMS@email.com	To Be Assigned	–Select Action–	Go
23	MD	Pending Info	Ken Gustafson	02/22/2016	New Monday Broker Test		Baltimore	MD	LMS Broker	(301)555-1212	lynn.starr@servarussystems.com	To Be Assigned	–Select Action–	Go
25	MD	Pending Info	Ken Gustafson	02/23/2016	Tuesday Test Enrollment Form		Baltimore	MD	LMS Broker	(410)555-1212	lms@gmail.com	To Be Assigned	–Select Action–	Go
26	MD	Incomplete			Video Demo, Inc.		Baltimore	MD	Lynn Broker	(301)555-1212	LMS@email.com	To Be Assigned	–Select Action–	Go
27	MD	Pending Info	Ken Gustafson	02/25/2016	Enrollment Validation, Inc.		Balitmore	MD	LMS Broker	(301)555-1212	LMS@email.com	To Be Assigned	–Select Action–	Go
28	MD	Pending Info	Ken Gustafson	02/24/2016	Enrollment Validation, II, Inc.		Baltimore	MD	LMS Broker	(301)555-1212	LMS@email.com	To Be Assigned	–Select Action–	Go
30	MD	Enroll	Ken Gustafson	03/01/2016	Demo Vido, Inc.		Baltimore	MD	Johnny Smith	(301)777-1212	jsmith@email.com	To Be Assigned	–Select Action–	Go
31	VA	Enroll	Ken Gustafson	03/01/2016	VA Demo		Richmond	VA	John Smith	(703)555-1212	lstarr@email.com	To Be Assigned	–Select Action–	Go

You may track the progress of the application by going to the **Check Application Status** screen. If there is more than one application in progress, a list of applications will be displayed (as seen above).

Incomplete — Licensed Producer has not submitted the application to the Employer for their review & signature <u>OR</u> the Employer has not finalized the application process.

Decline — Kaiser has declined the application.

Withdraw — Kaiser has withdrawn the application.

Pending Review — The Employer has completed and submitted the application for Kaiser's review.

Pending Info — Kaiser has reviewed the application and flagged areas of the application that require updating by the Licensed Producer.

Approved — Kaiser has approved the application and is in the process of internal setup of the group contract.

Enroll — Kaiser has completed the internal setup and group enrollment will be available on the Online Enrollment site.

AppID	Jurisdiction	Status	Approver	Submitted Date	Legal Name	DBA	City	State	Contact	Phone	Email	KP SalesRep	Actions	
5	MD	Approved	Ken Gustafson	02/10/2016	LMS MD Broker, Inc.		Baltimore	MD	Lynn Starr	(301)777-1212	lstarr@email.com	To Be Assigned	–Select Action–	Go
21	MD	Pending Info	Ken Gustafson	02/22/2016	Wednesday Test Broker		Baltimore	MD	Broker Smith	(301)777-1212	LMS@email.com	To Be Assigned	–Select Action–	Go
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25	MD	Pending Info	Ken Gustafson	02/23/2016	Tuesday Test Enrollment Form		Baltimore	MD	LMS Broker	(410)555-1212	lms@gmail.com	To Be Assigned	–Select Action–	Go
26	MD	Incomplete			Video Demo, Inc.		Baltimore	MD	Lynn Broker	(301)555-1212	LMS@email.com	To Be Assigned	–Select Action–	Go
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28	MD	Pending Info	Ken Gustafson	02/24/2016	Enrollment Validation, II, Inc.		Baltimore	MD	LMS Broker	(301)555-1212	LMS@email.com	To Be Assigned	–Select Action–	Go
30	MD	Enroll	Ken Gustafson	03/01/2016	Demo Vido, Inc.		Baltimore	MD	Johnny Smith	(301)777-1212	jsmith@email.com		View Application Files	Go
31	VA	Enroll	Ken Gustafson	03/01/2016	VA Demo		Richmond	VA	John Smith	(703)555-1212	lstarr@email.com	To Be Assigned	View Application PDF	Go

From here, you can view the uploaded documents from this screen by going to the **Actions** drop down menu and select **View Application Files**.

See Figure 9 as to how to determine the date and time stamp.

In addition you may view the most current version of the populated PDF by clicking on **View Application PDF**.

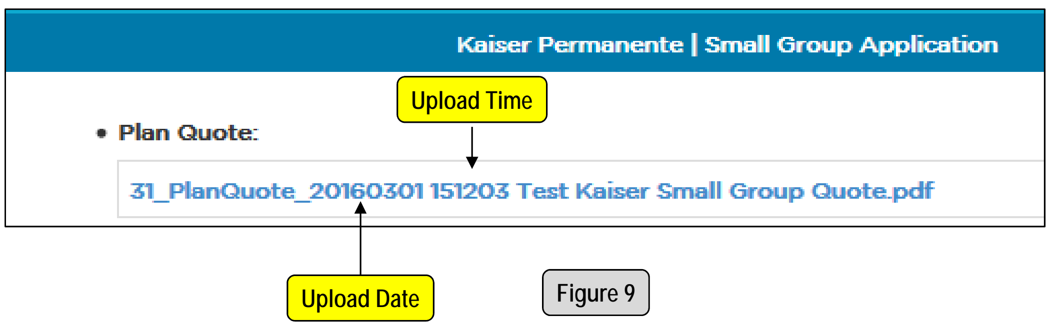

Figure 9

All documents that have been uploaded are saved with a date and time stamp. See Figure 6.

<u>Date Stamp</u>		<u>Time Stamp</u>	
2016	year	15	hour (in military time)
03	month	12	minutes
01	day	03	seconds

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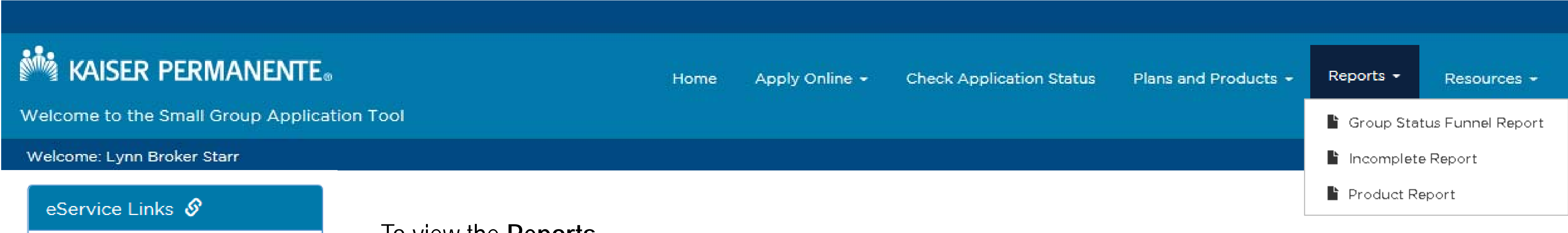


eService Links

Quote Now

Bill Now $

Quick Links

Kaiser Permanente Brokernet
Access import producer notification and information

Kaiser Permanente Selling Plans
Plan details and quoting for all employer sizes

Kaiser Permanente Your Clients
Secure access to your existing Kaiser Permanente book of business. Separate login required.

Kaiser Permanente Working With Us
Information on partnering with Kaiser Permanente including the broker code of conduct and commission details

Kaiser Permanente Resource Library
Printable forms, Kaiser Permanente contact information, and sales materials.

To view the **Reports**

- Click **Reports** from the top menu bar

Group Status Funnel Report

Provides the number of groups based on status while in the application process.

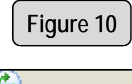
Incomplete Report

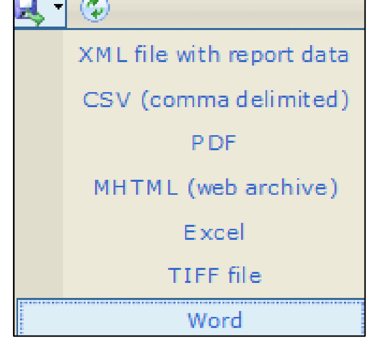
Provides a group listing of applications in progress that have not been submitted.

Product Report

Provides a list of all products and displays membership and group counts for submitted and approved applications.

Note: Reports can be downloaded to various file formats. **See Figure 10**..





How to Contact Us

Have Questions?
Contact Customer Service Center at 855-462-3400 Monday through Friday from 9 a.m. to 5 p.m. Eastern time or email us at onlineenrollment@onlinekp.com

We look forward to meeting and exceeding your health care expectations and experience.

Thank you

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