KAISER PERMANENTE CHOICE SOLUTION
A *CHOICE* Administrators® Program
www.kpchoicesolution.com

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Employer Change Request Form

Group Name ____________________ Group # ☐☐☐☐☐

RENEWAL ONLY Changes below are **only** allowed at Renewal (Anniversary Date)

❑ PREMIUM CONTRIBUTION CHANGE

Please select ONE option from items 1-3

Note: Dependent contributions are optional for employers.* If you wish to suppress contribution figures, please check option 4.†

OPTION 1 ❑ PERCENTAGE OF COST

STEP 1: Enter the percentage amount you will contribute toward:

Employee Premium: ____________% (50% minimum required) *Dependent Premium: ____________% (write 0 if none)

STEP 2: Apply contribution toward one HMO, POS, PPO, HDHP or ANY Plan Option (A, B, C, D or E)

A.	❑ **HMO 10** ❑ **HMO 30** ❑ **HMO 20/$1,000**
B.	❑ **POS 20/$1,000**
C.	❑ **PPO 30/$500**
D.	❑ **HDHP 1900**** ❑ **HDHP 2700****
E.	❑ Any plan selected by employee

***HSA-Qualified High Deductible Health Plan*

OPTION 2 ❑ EMPLOYER FIXED DOLLAR AMOUNT

Enter the dollar amount(s) you will contribute toward any plan selected by the employee:

$ ________for Employee
$ ________for Dependents*

OR

$ ________ Combined amount for Employee and Dependents*

OPTION 3 ❑ EMPLOYER DENTAL CONTRIBUTION

Enter the percentage amount you will contribute:

__________ % for Employee (50% minimum required)
__________ % for Dependents*

Applied toward: ❑ DHMO 200 ❑ PPO/FFS 1000 ❑ DHMO 250 ❑ PPO/FFS 1500

OPTION 4 ❑ SUPPRESS CONTRIBUTION†

Suppressing contributions will result in only full premium amounts reflected on invoices and worksheets. **Contribution must still be at least 50% of lowest cost plan for each employee.**

❑ CHANGE WAITING PERIOD TO:

❑ Date of Hire ❑ 30 days ❑ 60 days ❑ 90 days ❑ 180 days

All employees currently in the waiting period must either enroll at Renewal or be subject to the new waiting period selected.

❑ CHANGE HOURS OF ELIGIBILITY

❑ From 30+ to 20+ hours per week ❑ From 20+ to 30+ hours per week

I understand and agree to the following: 1) Coverage must be extended to all employees working the number of hours per week considered to be eligible. 2) 70% of employees working the number of hours per week considered to be eligible must enroll. 3) Employer contribution for all employees must be the same. 4) Once the Hours of Eligibility change becomes effective, it must be maintained until our anniversary date.

❑ ADD DENTAL

Employees will make their elections on the Renewal Change Request Form (Form # KP 0311)

Enter the percentage amount you will contribute:

__________ % for Employee (50% minimum required)
__________ % for Dependents*

Applied toward: ❑ DHMO 200 ❑ PPO/FFS 1000 ❑ DHMO 250 ❑ PPO/FFS 1500

*Note: Dependent contributions are optional for employers.**

(Continued on other side)

Group Plan Administrator Signature ____________________ Print Name ____________________ Date ____________________

OFF RENEWAL

❑ CHANGE ADDRESS/PHONE/FAX

Please list the group's new billing address below:
(❑ Check here if billing address and street address are the same)

Group's new **billing** address: ______ Street ______ City ______ State ______ Zip

Group's new **street** address: ______ Street ______ City ______ State ______ Zip

❑ Check here if phone and/or fax number has not changed

Please list group's new phone and/or fax number: ______ Phone number ______ Fax number

❑ ADD/CHANGE CONTACT

Please add the individual(s) listed below as the primary/additional contact(s). Only authorized contacts may obtain confidential information regarding the group.

Primary Contact ______ Title/Position ______

Direct Line ______ Email ______

Additional Contact ______ Title/Position ______

Direct Line ______ Email ______

Please remove the contacts listed below as they are no longer authorized to obtain confidential information on the group:

Remove Contact ______ Title/Position ______

Remove Contact ______ Title/Position ______

❑ ADD LIFE INSURANCE

Groups wishing to apply for Life amounts higher than the guaranteed issue amounts below must be medically underwritten. Please contact our Customer Service Center for more information.

Requirements:

1. 100% of eligible employees (whether enrolling or waiving medical) must enroll for life coverage. Employee Enrollment Applications (**Form KP 0310**) must be submitted by each employee with Sections A, D, & E completed.
2. A reconciled quarterly/annual wage report must be submitted with all employees accounted for (i.e. E=eligible, PT=part-time, T=terminated, S=seasonal, etc.)
3. 100% employer-paid premiums

Select a Flat amount for all employees:

Amount $: ______

# of eligible employees: ______

Guaranteed Issue Amounts		
Eligible Employees	**Minimum**	**Maximum**
2-5	$5,000	$5,000
6-10	$5,000	$10,000
11-25	$5,000	$25,000
25-50	$5,000	$50,000

❑ ADD SECTION 125

***A one time $100 Enrollment Fee must be submitted**

1. Name of Company President, Principal, or Partners: ______
2. Name of Corporate Secretary: (if applicable) ______
3. Plan Number: ______ (usually 501)
   (If not indicated, 501 will be used)
4. State of Incorporation (if applicable): ______
5. Company Structure:
   ❑ Corporation ❑ S Corporation ❑ Partnership ❑ Sole Proprietorship ❑ LLC ❑ Other______
6. Premium payments may be elected for: ❑ Medical ❑ Dental ❑ Other: ______
7. Last day of first Plan year: ____/____/____ (Approximately 364 days after the effective date of coverage) Subsequent plan years will be the 12 month period following this date.
   (If not indicated, last day of medical plan year will be used)

Participation Limitations

P.O.P. rules require that all participants in the plan be employees. Please be advised that 2% (or greater) shareholders in an S-Corporation, Sole Proprietors in a Sole Proprietorship and Partners in a Partnership are not considered employees as defined by Tax Code, and therefore are ineligible to participate in the P.O.P.

IMPORTANT

Read the information provided in the Kaiser Permanente Choice Solution Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

______ Group Name

______ Group Plan Administrator Signature

______ Date

______ Print Name

***Log onto www.kpchoicesolution.com (Broker or Employer log-in) to download forms and brochures**