



# Large Group Quote Request

For Kaiser Permanente Group Health Insurance Coverage

**Follow the four easy steps to request a Kaiser Permanente quote for groups of 51 or more employees.**

**KaiserQuotes.com**

phone: 1.877.752.4737  
facsimile: 1.866.439.9993

# Follow These Four Easy Steps...

To Request Your Kaiser Permanente Large Group Quote

## Large Group Checklist



### 1. Large Group Quote Request Form

Please complete and sign the two page application.



### 2. Employee Census Information

All eligible employees must be listed on the census. Please refer to the detailed census information on the attached sample copy.

(Note: The employee census spreadsheet must be submitted electronically. Please e-mail census information to [largegroup@kaiserquotes.com](mailto:largegroup@kaiserquotes.com). You may submit your current census, or click **Employee Census** to download a formatted Excel spreadsheet.)



### 3. Current Carrier Information

Provide copies of the following:

- Current Health Insurance Carrier(s)
- Current Plan Design(s) and Benefits
- Current Rates and/or Renewal Rates

(Note: If any of the above is missing, this will delay the processing of your quote. Please include any additional documentation available to assist underwriting.)



### 4. Submit Quote Request

The above documents may be submitted by fax, email, or mail, with the exception of the Employee Census Information, which must be submitted electronically.

Fax all documents to: **1.866.439.9993**

Email: **[largegroup@kaiserquotes.com](mailto:largegroup@kaiserquotes.com)**

Or mail to: **KaiserQuotes.com**

Attn: Large Group Department  
750 Mendocino Avenue, Suite 4  
Santa Rosa, CA 95401

Note: Once all documentation is completed and submitted, large group quotes for new business are often processed in five to seven business days. Underwriting may require up to fourteen business days to process quotes for groups that currently offer Kaiser Permanente. These times are estimations and may vary. Depending on the situation, underwriting may require additional documentation.

The following must be completed and signed by the employer for large groups requesting a quote from Kaiser Permanente.

## A. Contact Information

Business Name

Company Phone Number

Contact Person

Phone Number

Fax Number

E-mail Address

Address (Business Headquarters in California)

City

State

ZIP

Other Address (if applicable)

City

State

ZIP

## B. Employer Questionnaire

Current Renewal Date

Number of Employees

Employer Contribution Amounts

Tax ID Number

Purchaser ID Number (If previously with KPHP)

Are you currently offering Kaiser Permanente to your employees?

Yes

No

Would you like to offer Kaiser Permanente as a total solution for your company?

Yes

No, I would like to offer Kaiser Permanente alongside other carriers.

Uncertain

Which type of plan are you interested in?

HMO only

HMO and PPO/POS/OOA (Note: You will be asked to fill out an additional form if you desire to include PPO/POS/OOA coverage.)

Would you like your quote to include rates from Delta Dental?

Yes

No

Please quote with and without dental coverage.

Are you a statewide employer desiring to offer Kaiser Permanente to employees in both Northern and Southern California?

Yes

No

How long have you been offering a Group Health Insurance program to these employees?

Are your employees currently receiving health coverage through an association plan or through a PEO?

Describe your Employer Contribution Level and Strategy:

How many retirees are in your group? (Note: They must be identified on your Census.)

Over 65 \_\_\_\_\_

Under 65 \_\_\_\_\_

How many COBRA or State Continuation Eligible Participants are in your group? (Note: They must be identified on your Census.)

Please provide the following medical information to the best of your knowledge for all employees, retirees, COBRA participants and eligible dependents:

- List all ongoing claims (No Names) in the last 12 months that exceeded \$50,000. Include diagnosis and prognosis.

- How many are presently hospitalized or disabled?

As the employer, I understand and agree that the statements in this questionnaire are true and complete to the best of my knowledge.

Kaiser Permanente is issuing a rate quotation based on the answers provided above. If the answers to any of these questions are found to be untrue, Kaiser Permanente reserves the right to rescind this rate proposal.

\_\_\_\_\_  
EMPLOYER SIGNATURE AND TITLE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
KAISER PERMANENTE REPRESENTATIVE AND TITLE

Additional Comments or Questions:

Submit spreadsheet electronically to: [largegroup@kaiserquotes.com](mailto:largegroup@kaiserquotes.com)

## Employee Census must include the following:

- Name or Initials
- Date of Birth
- Gender
- Employment Status: Active, Retiree, Cobra, etc. Include start and finish dates for individuals on Cobra.
- Class: hourly, salary, union, etc.
- Residential Zip Code
- Current Carrier: Kaiser, Blue Cross, Health Net, etc.
- Benefit Plan Type: HMO, PPO, Indemnity, etc.
- Dependent Status: EE (employee), ES (employee and spouse), EC (employee and children), EF (employee and family)

Note: Do not include part time employees (less than 20 hours per week) or employees who are on 1099's.

Name/Initials	DOB	Gender	Employment Status	Class	Residence Zip Code	Current Carrier	Benefit Plan Type	Dependent Status
T. Banks	12/12/1958	M	Active	Hourly	95402	Kaiser	HMO	ES
J. Smith	04/29/1976	F	Active	Salary	95407	Blue Cross	HMO	EE
A. Reyna	06/12/1978	F	Active	Hourly	95408	Health Net	PPO	EC
Y. Grains	11/09/1948	M	Active	Union	95403	Kaiser	HMO	ES
O. Hansen	05/12/1958	F	Cobra 1/1/06 to 10/1/07	Hourly	95403	Blue Cross	POS	EE
F. Griggs	10/04/1967	F	Retiree	Salary	95407	Kaiser	HMO	EF
J. Burk	06/12/1958	M	Active	Hourly	95403	Kaiser	Indemnity	EC
K. Lions	07/02/1961	M	Active	Hourly	95403	Health Net	HMO	EE
W. Lions	01/18/1952	M	Active	Salary	95406	Blue Cross	PPO	EF
B. Jones	12/12/1958	F	Cobra 3/2/06 to 12/2/07	Hourly	95403	Kaiser	PPO	ES
G. Hopps	06/12/1958	M	Active	Union	95403	Blue Cross	HMO	EE
N. Lee	04/29/1976	F	Retiree	Hourly	95406	Kaiser	HMO	EC

You may submit your current census, or click [Employee Census](#) to download a formatted Excel spreadsheet.

# Eligibility Requirements

Detailed Eligibility Requirements Will Accompany Your Quote.

- »» Only full time employees are eligible for coverage. Employees must work a minimum of 20 hours per week in order to qualify as full time.
- »» Employer/employee relationship is required. Contract or 1099 employees are not eligible.
- »» Minimum employer contribution is 50% of employee only rate.
- »» At least 70% of the eligible employees who have satisfied their waiting period must enroll in either Kaiser Permanente or another group health plan offered by the company, excluding those who have coverage through a spouse's plan.
- »» A minimum of three subscribers must enroll in Kaiser Permanente. If the employer has statewide employees, a minimum of three subscribers must enroll in the Southern California Region and three subscribers must enroll in the Northern California Region.
- »» Kaiser Permanente will not accept or quote on new groups whose COBRA membership is 15% or more of the total number of employees participating in the group's health plan(s).