KAISER PERMANENTE®

Employee census form

Instructions

Please list all current employees on your payroll. Indicate each employee's eligibility for medical coverage, including those employees waiving coverage. If married employees plan to enroll separately, please list them separately, and indicate how many children each plans to enroll as dependents.

Rates will be based on this census. We will re-rate based on actual enrollment and adjust the rates accordingly.

Note: "Current employee" includes owners, sole proprietors, partners of a partnership, or independent contractors that are included as employees under a health benefit plan of a small employer. Employees who work on a temporary, seasonal, or substitute basis are not eligible. The employer contribution must be at least 50 percent of the employee-only rate.

Enrollment key

Family enrollment status

01 Employee only
02 Employee + spouse
03 Employee + spouse + child(ren)
04 Employee + child(ren)

Other status

G Waiving to other group coverage
NP Has not served waiting period
NH Not enough hours to qualify for coverage
W Waiving to no other coverage

Business name _____ Date _____

Business address _____ Group contact _____

City, State, ZIP _____ Effective date _____

Phone number _____ Fax number _____

Current carrier (If insured) _____ Current agent/broker _____

E-mail address _____

Name	DOB or age	Gender	Hours per week	Hire date	Eligible for coverage	Spouse	Number of dependent children*	Employee ZIP code	Enrollment code (see key)
1		M F			Y N	Y N			
2		M F			Y N	Y N			
3		M F			Y N	Y N			
4		M F			Y N	Y N			
5		M F			Y N	Y N			
6		M F			Y N	Y N			
7		M F			Y N	Y N			
8		M F			Y N	Y N			
9		M F			Y N	Y N			
10		M F			Y N	Y N			
11		M F			Y N	Y N			
12		M F			Y N	Y N			

** If the enrollment code selected is 03 or 04, you must indicate the number of dependent children. If not, we will assume two (2) children, and the rates may be incorrect.*

As the authorized group representative, I confirm that the above information is correct. I understand and agree that Kaiser Foundation Health Plan of the Northwest reserves the right to deny enrollment to the entire group if the group enrollment criteria stated in the underwriting guidelines are not met.

Signature of authorized representative _____ Title _____

Questions? Call us at 1-800-813-2630 or 503-813-2630. Fax to 503-813-4426 or mail to Kaiser Permanente, Attn: SBG, 500 NE Multnomah St., Suite 100, Portland, OR 97232. E-mail to NW.Small.Business@kp.org

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