KAISER PERMANENTE®

Small Business
# CENSUS

## INSTRUCTIONS

For a no-obligation rate quote, complete the form below and email to **kaiser.sbu.sales@kp.org**. Please list all employees who are eligible for health care benefits.

## COMPANY INFORMATION

Company name

Street address (no P.O. boxes)

| | | | |
|---|---|---|---|
| City | State | ZIP | County |
| Office phone<br>( ) – | Ext. | Fax<br>( ) – | |
| Number of employees who are eligible for health coverage | | Current carrier | |

## BROKER INFORMATION

| | |
|---|---|
| Firm name | Kaiser Permanente firm ID |
| Agent name | Agency license # |

| | | | | |
|---|---|---|---|---|
| Office phone<br>( ) – | Ext. | Fax<br>( ) – | Cell phone<br>( ) – | Email |

| | | | |
|---|---|---|---|
| Street address | City | State | ZIP |

## STRATEGY (OPTIONAL)

☐ Sole Carrier ☐ Slice ☐ Multiple Plan Offering ☐ Account-Based Plans ☐ Workforce Health

## EMPLOYEE/DEPENDENT ELIGIBILITY INFORMATION*

List all employees, owners, and dependents you'd like quoted. A dependent is a spouse, domestic partner, child or domestic partner's child. Use additional page, as needed.
*For each employee/dependent listed, all fields must be filled out completely to process this form.

| First name | Last name or initial | Date of birth (mm/dd/yyyy) or age | Home ZIP | Relationship (check one) |
|---|---|---|---|---|
| | | | | ☐ Employee/owner ☐ Spouse ☐ Child |
| | | | | ☐ Employee/owner ☐ Spouse ☐ Child |
| | | | | ☐ Employee/owner ☐ Spouse ☐ Child |
| | | | | ☐ Employee/owner ☐ Spouse ☐ Child |

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## CONTACT INFORMATION

For more information, please contact Kaiser Permanente at **800-789-4661**, option 2.

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## EMPLOYEE/DEPENDENT ELIGIBILITY INFORMATION* *(continued from page 1)*

Company name

*For each employee/dependent listed, all fields must be filled out completely to process this form.

| First name | Last name or initial | Date of birth (mm/dd/yyyy) or age | Home ZIP | Relationship (check one) | | |
|---|---|---|---|---|---|---|
| | | | | ☐ Employee/owner | ☐ Spouse | ☐ Child |
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