

**EMPLOYER'S CONFIRMATION  
OF WORKERS' COMPENSATION****1 COMPANY INFORMATION**

Company name		Group ID
Phone (       )       -	Fax (       )       -	
<input type="checkbox"/> Check here if phone or fax has changed.		

**2 WORKERS' COMPENSATION**

All employees must be covered by workers' compensation, unless not required to be covered by law. I attest that the following information is correct.

- ☐ Workers' compensation carrier: \_\_\_\_\_
- ☐ Exempt – I'm exempt from providing workers' compensation coverage for the following reason:

\_\_\_\_\_

Please note: Owner/partners are covered by Kaiser Permanente 24 hours a day while at work and aren't required to cover themselves for workers' compensation.

**3 READ AND SIGN**

I affirm that I have authority to contract with Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company on behalf of the group. I understand that this information may be subject to verification and agree to provide Kaiser Foundation Health Plan, Inc., with any information necessary to do so. I also understand that failure to meet the above conditions may result in denial or termination of group health coverage from Health Plan for the above-named company.

Authorized company signer (please print name)	Company title (please print)
Signature <b>X</b>	Date