



Small Business
**EMPLOYER'S CONFIRMATION
OF WORKERS' COMPENSATION**

1 COMPANY INFORMATION

Company name	Group ID
Phone () -	Fax () -

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 X	Date