



Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon
 100 SW Market Street
 PO Box 1271
 Portland, OR 97201

**Application for New Group Coverage/Contract Change Form
 Oregon Groups of 100+**

Legal Name of Employer		Tax Identification Number		Requested Effective Date	
Group Administrator Name		Title		Renewal Advance Notice: <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> Other	
Group Administrator E-Mail Address		Company Web site		Telephone Number	
Billing Contact Name		Title		Fax Number	
Business Street Address (not PO Box)		City		State	
Billing Address		City		State	
Industry Description		Type of Industry: <input type="checkbox"/> Sic Code _____ <input type="checkbox"/> NAICS _____		Workers' Compensation Carrier	
				Prior Medical Carrier Name	
				Prior Dental Carrier Name	

Where do the majority of the group employees work? Oregon Washington Other _____

Do you file consolidated taxes? Yes No

Company headquartered in: Oregon Washington Other _____

FOR PLAN LISTED BELOW:

Eligibility: This Plan will Cover: <input type="checkbox"/> Employees & Dependents (includes Oregon-Certified Domestic Partners) <input type="checkbox"/> Employees Only <input type="checkbox"/> Non-Certified Domestic Partners	Employer Contribution to Premium: <table style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td style="text-align: center;">Medical</td> <td style="text-align: center;">Dental</td> </tr> <tr> <td>Employee</td> <td style="text-align: center;">_____ %</td> <td style="text-align: center;">_____ %</td> </tr> <tr> <td>Dependent</td> <td style="text-align: center;">_____ %</td> <td style="text-align: center;">_____ %</td> </tr> </table>		Medical	Dental	Employee	_____ %	_____ %	Dependent	_____ %	_____ %	Full-Time Employees: (Number of hours required for coverage) Oregon _____ Hrs (17.5 - 40)
		Medical	Dental								
	Employee	_____ %	_____ %								
Dependent	_____ %	_____ %									

Class of Employees: All Eligible Management Non Management
 Salaried Hourly Other _____

Medical Choice: <input type="checkbox"/> BlueEssentials SM <input type="checkbox"/> BluePreferred [®] <input type="checkbox"/> BlueClassic SM <input type="checkbox"/> Basic Oregon Plan - Traditional (only for group size of 2-50) <input type="checkbox"/> Regence HSA Healthplan (includes prescription) <input type="checkbox"/> Participating <input type="checkbox"/> Preferred <input type="checkbox"/> \$1,500 single / \$3,000 family ** <input type="checkbox"/> \$2,500 single / \$5,000 family ** <input type="checkbox"/> \$3,500 single / \$7,000 family ** <input type="checkbox"/> \$3,000 single / \$5,000 family *** <input type="checkbox"/> \$3,000 single / \$7,000 family *** <input type="checkbox"/> Other Medical Plan _____ <input type="checkbox"/> Medical Plan not applicable	Deductible Choice: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$3000 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> Participating <input type="checkbox"/> Preferred Provider Plan <input type="checkbox"/> Participating <input type="checkbox"/> Preferred Provider Plan <input type="checkbox"/> Participating <input type="checkbox"/> Preferred Provider Plan	Network Choice: <input type="checkbox"/> Participating <input type="checkbox"/> Preferred Provider Plan <input type="checkbox"/> Participating <input type="checkbox"/> Preferred Provider Plan <input type="checkbox"/> Participating <input type="checkbox"/> Preferred Provider Plan	Dental: <input type="checkbox"/> Fee-for-Service _____ <input type="checkbox"/> Dentacare _____ <input type="checkbox"/> Orthodontia _____ <input type="checkbox"/> Basic Oregon Plan Dental (only for group size of 2-50) <input type="checkbox"/> Dental not applicable	Prescription*: <input type="checkbox"/> \$10/\$20/\$40 <input type="checkbox"/> \$10/30%/50% <input type="checkbox"/> 50% <input type="checkbox"/> \$10/\$35/\$50 <input type="checkbox"/> Prescription not applicable * Not applicable to Regence HSA Healthplan	Vision: <input type="checkbox"/> \$20 Copayment <input type="checkbox"/> Basic Oregon Plan Vision (only for group size of 2-50) <input type="checkbox"/> Vision Plan for Regence HSA Healthplans only <input type="checkbox"/> Vision not applicable	Alternative Care Options*: <input type="checkbox"/> \$20 Complementary Care <input type="checkbox"/> \$500 max <input type="checkbox"/> \$1000 max <input type="checkbox"/> Alternative Care options not applicable * Not applicable to Regence HSA Healthplan
---	--	---	---	--	---	---

Eligibility: This Plan will Cover: <input type="checkbox"/> Employees & Dependents (includes Oregon-Certified Domestic Partners) <input type="checkbox"/> Employees Only <input type="checkbox"/> Non-Certified Domestic Partners	Employer Contribution to Premium: <table style="width:100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Medical</td> <td style="text-align: center;">Dental</td> </tr> <tr> <td>Employee</td> <td style="text-align: center;">_____ %</td> <td style="text-align: center;">_____ %</td> </tr> <tr> <td>Dependent</td> <td style="text-align: center;">_____ %</td> <td style="text-align: center;">_____ %</td> </tr> </table>		Medical	Dental	Employee	_____ %	_____ %	Dependent	_____ %	_____ %	Full-Time Employees: (Number of hours required for coverage) Oregon _____ Hrs (17.5 - 40)
	Medical	Dental									
Employee	_____ %	_____ %									
Dependent	_____ %	_____ %									

Class of Employees: All Eligible Management Non Management
 Salaried Hourly Other _____

Medical Choice: <input type="checkbox"/> BlueEssentials SM <input type="checkbox"/> BluePreferred [®] <input type="checkbox"/> BlueClassic SM <input type="checkbox"/> Basic Oregon Plan - Traditional (only for group size of 2-50) <input type="checkbox"/> Regence HSA Healthplan (includes prescription) <input type="checkbox"/> Participating <input type="checkbox"/> Preferred <input type="checkbox"/> \$1,500 single / \$3,000 family * <input type="checkbox"/> \$2,500 single / \$5,000 family * <input type="checkbox"/> \$3,500 single / \$7,000 family * <input type="checkbox"/> \$3,000 single / \$5,000 family ** <input type="checkbox"/> \$3,000 single / \$7,000 family ** <input type="checkbox"/> Other Medical Plan _____ <input type="checkbox"/> Medical Plan not applicable	Deductible Choice: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$3000 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000	Network Choice: <input type="checkbox"/> Participating <input type="checkbox"/> Preferred Provider Plan <input type="checkbox"/> Participating <input type="checkbox"/> Preferred Provider Plan <input type="checkbox"/> Participating <input type="checkbox"/> Preferred Provider Plan	Dental: <input type="checkbox"/> Fee-for-Service _____ <input type="checkbox"/> Dentacare _____ <input type="checkbox"/> Orthodontia _____ <input type="checkbox"/> Basic Oregon Plan Dental (only for group size of 2-50) <input type="checkbox"/> Dental not applicable	Prescription*: <input type="checkbox"/> \$10/\$20/\$40 <input type="checkbox"/> \$10/30%/50% <input type="checkbox"/> 50% <input type="checkbox"/> \$10/\$35/\$50 <input type="checkbox"/> Prescription not applicable * Not applicable to Regence HSA Healthplan
			Vision: <input type="checkbox"/> \$20 Copayment <input type="checkbox"/> Basic Oregon Plan Vision (only for group size of 2-50) <input type="checkbox"/> Vision Plan for Regence HSA Healthplans only <input type="checkbox"/> Vision not applicable	Alternative Care Options*: <input type="checkbox"/> \$20 Complementary Care <input type="checkbox"/> \$500 max <input type="checkbox"/> \$1000 max <input type="checkbox"/> Alternative Care options not applicable * Not applicable to Regence HSA Healthplan

Health Reimbursement Arrangement:

If yes, list carrier/third party administrator:

Do you currently have, or are you selecting: Health Reimbursement Arrangement (HRA): No Yes _____
Group authorization initials _____ Flexible Spending Account (FSA): No Yes _____

Is your group COBRA* eligible? Yes No *20 or more full-time and/or part-time employees on 50% or more of your business days in the preceding calendar year.
Will your group offer COBRA to domestic partners? Yes No

Participation: Group is subject to underwriting guidelines currently in effect.

Total number of employees _____ Total number of employees currently eligible for coverage _____
Average number of employees in the preceding calendar year _____ Total number of employees enrolling _____
Current number of eligible employees working 17.5 hours or more _____

New Employee Waiting Period: New full-time employees are eligible for coverage the first of the month following your group's waiting period.

First of the month following date of hire 30 Days 60 Days 90 Days 120 Days* 180 Days*, or Date of Hire*
Would you like to waive the new employee waiting period for existing employees at initial enrollment? Yes No
*Not available for group size 2-50

Federal Mandates:

OBRA:
Group subject to OBRA? Yes No
If you employed 100 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January - December) you are subject to federal OBRA 1989/OBRA 1993 laws.

TEFRA/DEFRA:
Group subject to TEFRA/DEFRA? Yes No
If you employed 20 or more full-time and/or part-time employees during each of 20 calendar weeks in the current or preceding calendar year (January - December) you are subject to federal TEFRA/DEFRA laws.

Producer of Record: _____
(Print Producer's Name & Seven Digit Number)

For a description of producer compensation, please visit www.or.regence.com.

On behalf of our group, I hereby make application to Regence BlueCross BlueShield of Oregon (Regence BCBSO) for the group contract(s) indicated above. I certify that I am an officer or employee of the group, and that I am duly authorized to execute this application on behalf of the group. I acknowledge there is no coverage in effect until Regence BCBSO accepts this application and premium deposit, establishes an effective date of coverage and issues the group contract(s) to us. If the application is not accepted, the premium deposit submitted with this application will be refunded.

For the protection of all of our members, fraud or misrepresentation of material fact by me and/or the Group for the purposes of defrauding Regence BCBSO may result in Regence BCBSO taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

I hereby acknowledge receipt of the Medicare Secondary Payer (MSP) Disclosure Statement, the Outline of Coverage Forms (Benefit Summaries), the Benefit Comparison, and the receipt of the Notice of Privacy Practices, as required by state law. In addition, I hereby appoint the above producer of record to represent us in matters of group coverage benefits provided by Regence BCBSO. This appointment is in effect on the same day as this contract(s) and will remain in force until rescinded in writing.

I hereby certify there will be no other medical carrier in conjunction with this plan except when this group has employees residing outside the service area or underwriting approval has been given in advance to split with another carrier. I also certify that all information provided regarding Health Reimbursement Arrangements is true and correct.

(Group Authorization Signature) (Date) (Authorized Signer's Title)

IF ADDITIONAL PLANS ARE OFFERED:

<p>Eligibility: This Plan will Cover:</p> <p><input type="checkbox"/> Employees & Dependents (includes Oregon-Certified Domestic Partners)</p> <p><input type="checkbox"/> Employees Only</p> <p><input type="checkbox"/> Non-Certified Domestic Partners</p>	<p>Employer Contribution to Premium:</p> <table style="width:100%; border: none;"> <tr> <td></td> <td align="center">Medical</td> <td align="center">Dental</td> </tr> <tr> <td>Employee</td> <td align="center">_____ %</td> <td align="center">_____ %</td> </tr> <tr> <td>Dependent</td> <td align="center">_____ %</td> <td align="center">_____ %</td> </tr> </table>		Medical	Dental	Employee	_____ %	_____ %	Dependent	_____ %	_____ %	<p>Full-Time Employees: (Number of hours required for coverage)</p> <p>Oregon _____ Hrs (17.5 - 40)</p>
	Medical	Dental									
Employee	_____ %	_____ %									
Dependent	_____ %	_____ %									
<p>Class of Employees:</p> <p><input type="checkbox"/> All Eligible <input type="checkbox"/> Management <input type="checkbox"/> Non Management</p> <p><input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Other _____</p>											
<p>Medical Choice:</p> <p><input type="checkbox"/> BlueEssentialsSM</p> <p><input type="checkbox"/> BluePreferred[®]</p> <p><input type="checkbox"/> BlueClassicSM</p> <p><input type="checkbox"/> Basic Oregon Plan - Traditional (only for group size of 2-50)</p> <p><input type="checkbox"/> Regence HSA Healthplan (includes prescription)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Participating <input type="checkbox"/> Preferred</p> <p style="margin-left: 40px;"><input type="checkbox"/> \$1,500 single / \$3,000 family *</p> <p style="margin-left: 40px;"><input type="checkbox"/> \$2,500 single / \$5,000 family *</p> <p style="margin-left: 40px;"><input type="checkbox"/> \$3,500 single / \$7,000 family *</p> <p style="margin-left: 40px;"><input type="checkbox"/> \$3,000 single / \$5,000 family **</p> <p style="margin-left: 40px;"><input type="checkbox"/> \$3,000 single / \$7,000 family **</p> <p><input type="checkbox"/> Other Medical Plan _____</p>	<p>Deductible Choice:</p> <p><input type="checkbox"/> \$500</p> <p><input type="checkbox"/> \$1000</p> <p><input type="checkbox"/> \$2000</p> <p><input type="checkbox"/> \$250</p> <p><input type="checkbox"/> \$300</p> <p><input type="checkbox"/> \$500</p> <p><input type="checkbox"/> \$1000</p> <p><input type="checkbox"/> \$2000</p> <p><input type="checkbox"/> \$3000</p> <p><input type="checkbox"/> \$250</p> <p><input type="checkbox"/> \$300</p> <p><input type="checkbox"/> \$500</p> <p><input type="checkbox"/> \$1000</p>	<p>Network Choice:</p> <p><input type="checkbox"/> Participating</p> <p><input type="checkbox"/> Preferred Provider Plan</p> <p><input type="checkbox"/> Participating</p> <p><input type="checkbox"/> Preferred Provider Plan</p> <p><input type="checkbox"/> Participating</p> <p><input type="checkbox"/> Preferred Provider Plan</p> <p><input type="checkbox"/> Medical Plan not applicable</p>	<p>Dental:</p> <p><input type="checkbox"/> Fee-for-Service _____</p> <p><input type="checkbox"/> Dentacare _____</p> <p><input type="checkbox"/> Orthodontia _____</p> <p><input type="checkbox"/> Basic Oregon Plan Dental (only for group size of 2-50)</p> <p><input type="checkbox"/> Dental not applicable</p>	<p>Prescription*:</p> <p><input type="checkbox"/> \$10/\$20/\$40</p> <p><input type="checkbox"/> \$10/30%/50%</p> <p><input type="checkbox"/> 50%</p> <p><input type="checkbox"/> \$10/\$35/\$50</p> <p><input type="checkbox"/> Prescription not applicable</p> <p>* Not applicable to Regence HSA Healthplan</p>	<p>Vision:</p> <p><input type="checkbox"/> \$20 Copayment</p> <p><input type="checkbox"/> Basic Oregon Plan Vision (only for group size of 2-50)</p> <p><input type="checkbox"/> Vision Plan for Regence HSA Healthplans only</p> <p><input type="checkbox"/> Vision not applicable</p>	<p>Alternative Care Options*:</p> <p><input type="checkbox"/> \$20 Complementary Care</p> <p style="margin-left: 20px;"><input type="checkbox"/> \$500 max <input type="checkbox"/> \$1000 max</p> <p><input type="checkbox"/> Alternative Care options not applicable</p> <p>* Not applicable to Regence HSA Healthplan</p>					