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
Clark County, Washington Groups of 100+

Legal Name of Employer	Tax Identification Number	Requested Effective Date

Group Administrator Name	Title	Renewal Advance Notice: ☐ 30 days ☐ 60 days ☐ Other

Group Administrator E-Mail Address	Company Web site	Telephone Number ( )	Fax Number ( )
Billing Contact Name	Title	Telephone Number ( )	Fax Number ( )

Business Street Address (not PO Box)	City	State	ZIP Code	County

Billing Address	City	State	ZIP Code

Industry Description	Type of Industry: ☐ Sic Code ____ ☐ 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:
- ☐ Employees & Dependents (includes any State-Registered Domestic Partners)
- ☐ Employees Only
- ☐ Non-Registered Domestic Partners

Employer Contribution to Premium:

	Medical	Dental
Employee	____%	____%
Dependent	____%	____%

Full-Time Employees:
(Number of hours required for coverage)

Washington ________ Hrs (20 - 40)

Class of Employees: ☐ All Eligible ☐ Management ☐ Non Management ☐ Salaried ☐ Hourly ☐ Other ____________

Medical Choice:	Deductible Choice:	Network Choice:
☐ BlueEssentials℠	☐ $500 ☐ $1000 ☐ $2000	☐ Participating ☐ Preferred Provider Plan
☐ BluePreferred®	☐ $250 ☐ $300 ☐ $500 ☐ $1000 ☐ $2000 ☐ $3000	☐ Participating ☐ Preferred Provider Plan
☐ BlueClassic℠	☐ $250 ☐ $300 ☐ $500 ☐ $1000	☐ Participating ☐ Preferred Provider Plan

☐ Regence HSA Healthplan (includes prescription)

☐ Participating ☐ Preferred
- ☐ $1,500 single / $3,000 family **
- ☐ $2,500 single / $5,000 family **
- ☐ $3,500 single / $7,000 family **
- ☐ $3,000 single / $5,000 family ***
- ☐ $3,000 single / $7,000 family ***

** Family consists of more than one member. Entire family deductible must be met before benefits begin for any family member.

*** Benefits begin for a member once $3,000 amount is met or once the family deductible is met, whichever occurs first.

☐ Other Medical Plan ____________ ☐ Medical Plan not applicable

Dental:
- ☐ Fee-for-Service ____________
- ☐ Dentacare ____________
- ☐ Orthodontia ____________
- ☐ Dental not applicable

Prescription*:
- ☐ $10/$20/$40
- ☐ $10/30%/50%
- ☐ 50%
- ☐ $10/$35/$50
- ☐ Prescription not applicable

* Not applicable to Regence HSA Healthplan

Vision:
- ☐ $20 Copayment
- ☐ Vision Plan for Regence HSA Healthplans only
- ☐ Vision not applicable

Alternative Care Options*:
- ☐ $20 Complementary Care
  - ☐ $500 max ☐ $1000 max
- ☐ Alternative Care options not applicable

* Not applicable to Regence HSA Healthplan

Eligibility: This Plan will Cover:

- ☐ Employees & Dependents (includes any State-Registered Domestic Partners)
- ☐ Employees Only
- ☐ Non-Registered Domestic Partners

Employer Contribution to Premium:

	Medical	Dental
Employee	____ %	____ %
Dependent	____ %	____ %

Full-Time Employees:
(Number of hours required for coverage)

Washington ____________ Hrs (20 - 40)

Class of Employees: ☐ All Eligible ☐ Management ☐ Non Management ☐ Salaried ☐ Hourly ☐ Other ____________

Medical Choice:	**Deductible Choice:**	**Network Choice:**
☐ BlueEssentials℠	☐ $500 ☐ $1000 ☐ $2000	☐ Participating ☐ Preferred Provider Plan
☐ BluePreferred ®	☐ $250 ☐ $300 ☐ $500 ☐ $1000 ☐ $2000 ☐ $3000	☐ Participating ☐ Preferred Provider Plan
☐ BlueClassic℠	☐ $250 ☐ $300 ☐ $500 ☐ $1000	☐ Participating ☐ Preferred Provider Plan

☐ Regence HSA Healthplan (includes prescription)

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- ☐ $1,500 single / $3,000 family *
- ☐ $2,500 single / $5,000 family *
- ☐ $3,500 single / $7,000 family *
- ☐ $3,000 single / $5,000 family **
- ☐ $3,000 single / $7,000 family **

* Family consists of more than one member. Entire family deductible must be met before benefits begin for any family member.

** Benefits begin for a member once $3,000 amount is met or once the family deductible is met, whichever occurs first.

☐ Other Medical Plan ____________ ☐ Medical Plan not applicable

Dental:

- ☐ Fee-for-Service ____________
- ☐ Dentacare ____________
- ☐ Orthodontia ____________
- ☐ Dental not applicable

Prescription*:

- ☐ $10/$20/$40
- ☐ $10/30%/50%
- ☐ 50%
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  - ☐ $500 max ☐ $1000 max
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Health Reimbursement Arrangement:

If yes, list carrier/third party administrator:

Do you currently have, or are you selecting:

Group authorization initials ______

Health Reimbursement Arrangement (HRA): ☐ No ☐ Yes ______

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 Washington continuation? ☐ Yes ☐ No

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 ______

Average number of employees on payroll in the preceding calendar year, regardless of hours worked ______

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

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.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. 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:

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