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

GROUP ROSTER

For Internal Use Only

Group Number ____________________

Legal Name of Employer ____

Please list all employees and provide the information requested. This roster is part of your group file. It must be completed, signed and dated by the employer's authorized representative. In lieu of this form, system-generated information is acceptable. Regence BlueCross BlueShield of Oregon may request payroll records for employees listed.

An employee is one who works on a regular scheduled basis, 50% or more during the previous year. The employer determines the waiting (probationary) period for new hires in addition to the number of hours employees must work to be "eligible" for group insurance. Indicate your business requirements below. **See reverse side for field definitions.**

Waiting (probationary) period ____________________ Number of hours per week employees must work to be eligible for insurance ____________

Oregon and Clark County groups: Average number of employees in preceding calendar year ____________

Employee Legal Last Name	Employee Legal First Name	Job Title	State Employed	Employee Birthdate mm/dd/yyyy	Hours Worked Per Week	Date of Hire mm/dd/yyyy	Spouse Yes/No	Number of Children (Excluding Emp & Spouse)	Enrollment Code * Employee	Enrollment Code * Spouse/Child	COBRA or Cont. - Check if Yes	**(If Regence Life and Health Sold)**	
												Gender	Salary

* **Enrollment Codes for:**

Employee Enrolling: **01** = Employee only **02** = Employee and Spouse **03** = Employee and Child **04** = Employee, Spouse, and Child(ren) **05** = Employee and Child(ren)

OR

Employee and/or Dependent Not Enrolling: **A** = Medicaid **C** = Ineligible Class **F** = Contracted Employee (i.e., temporary Bookkeeper) **G** = Other Group Insurance **H** = Hours Insufficient **I** = Other Individual Coverage **M** = Medicare/High Risk Pool **P** = Waiting Period Not Served **S** = Spouse of another Employee **V** = Veteran/Champus Coverage **W** = Waived Coverage **X** = COBRA **U** = Indian Health Service

I understand and agree that all information listed is true and correctly recorded:

▶ ______________________________ ____________________ ____________

Signature of Authorized Representative Title Date

FIELD DEFINITIONS

Employee Legal Last Name; include Jr. or Sr., if applicable: Employees who work on a regularly scheduled basis (this may include owners). Do not include employees who work on a temporary, seasonal or substitute basis. This does not mean only employees that qualify for coverage.

Employee First Name: Legal First.

Job Title: Job title for each employee.

State Employed: State in which the employee works.

Employee Birthdate: Include month, day, and year in the following format: MM/DD/YYYY.

Hours Worked Per Week: Number of hours an employee works per week on a regular basis. Include for all employees whether or not they are enrolling.

Date of Hire: Complete field in MM/DD/YYYY format.

Spouse: Means legal spouse or eligible domestic partner (DP).

Number of Dependents: Indicate number of dependents, regardless of whether dependents are enrolling (excluding employee and spouse).

Enrollment Code - Employee: Refer to enrollment codes on front of form for definitions. Indicate one enrollment code for every employee, regardless of whether they are enrolling. PLEASE NOTE: Code for "enrolling" must match enrollment application for each employee.

Enrollment Code - Spouse/Domestic Partner and Dependent: Refer to enrollment codes on front of form for definitions. Indicate one enrollment code for every spouse and/or dependent, regardless of whether they are enrolling. PLEASE NOTE: Code for "enrolling" must match enrollment application for each spouse and/or dependent.

COBRA or Continuation: Mark "Yes" only for employees who are currently enrolled in COBRA or State Continuation.

If Regence Life and Health Sold: Only complete this field if group is purchasing life or disability benefits.

Signature of Authorized Representative: An authorized representative of the group.

Please be sure to obtain and retain a signed Declination of Coverage form for all employees not enrolled on your current group coverage.

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 BlueCross BlueShield of Oregon may result in Regence BlueCross BlueShield of Oregon 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.

Employee Legal Last Name	Employee Legal First Name	Job Title	State Employed	Employee Birthdate mm/dd/yyyy	Hours Worked Per Week	Date of Hire mm/dd/yyyy	Spouse Yes/No	Number of Children (Excluding Emp & Spouse)	Enrollment Code * Employee	Enrollment Code * Spouse/Child	COBRA or Cont. - Check if Yes	**(If Regence Life and Health Sold)**	
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