



Regence BlueCross BlueShield of Oregon

An Independent Licensee of the Blue Cross and Blue Shield Association

Rating Type Rep # Renewal Date Adv Notice

Date

Group Name

Attn:

Address

City, State Zip Code

Regence BlueCross BlueShield Group Number _____

Regulation requires us to manually certify the size of our Employer Health Insurance Groups. Please complete and return this form in the postage paid envelope enclosed, no later than 14 days from the date of this letter. NOTE: We are unable to renew your group's coverage without this information. If you have questions, please contact your Sales Team.

*If you are requesting coverage as a single group because you are an affiliated group of employers for the purpose of pension plans under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986, the carrier must treat the affiliated group as a single group and the affiliated group must fill out one group profile form. If you are an affiliated group of employers but are not requesting coverage as a single group, each employer group in the affiliated group must fill out a separate group profile form.

Average number of employees during preceding calendar year: _____

If the average number of employees is 51 or greater, the group may qualify as a large group*. If the average number of employees is at least two but not more than 50 during the preceding calendar year and you have at least two but not more than 50 eligible employees as of the date coverage is to take effect, you are a small employer.

Did more than 50 percent of the average number of employees work in Oregon during the preceding calendar year? _____ Yes _____ No

Number of eligible employees (see the following definition) as of the date coverage is to take effect: _____

Definition: This is the number of employees who work a regular schedule of 17.5 hours or more per week on the date coverage is to take effect. Eligible employees do not include employees who work on a temporary, seasonal, or substitute basis.

Health plan quote(s) will be based on the size of your group, in compliance with ORS 743.730.

Continue to next page

Disclosure for Employer

If an employer has an average of more than 50 employees during the preceding calendar year, the carrier may provide the employer a health insurance quote as a large group. However, the carrier must treat an employer as a small employer and must provide a quote on that basis if both of the following conditions apply:

- (1) The employer's workforce consists of at least two but not more than 50 eligible employees as of the date coverage is to take effect; and
- (2) Coverage is limited to eligible employees.

Health insurance carriers are required to provide quotes and issue coverage to small employers pursuant to ORS 743.733 to ORS 743.737.

NOTE: Regence BlueCross BlueShield of Oregon is providing a small group quote based upon the State's definition of a Small Employer.

1. What **percentage** of premium do you (the employer) pay toward your employee and dependent insurance coverage?

Employee:	100%	75%	50%	0%	Other _____
Dependent:	100%	75%	50%	0%	Other _____

2. Are you providing deductible funding, HRA/HSA or cash back arrangements? _____ Yes _____ No

3. Where is your group headquartered? (City, State) _____ City _____ State

4. Of your enrolled employees, indicate the number of employees in the following categories:

Currently enrolled employees (on your monthly billing statement)	_____
COBRA/OR Continuation	_____
Employees enrolled as a spouse of another employee	_____

5. Of those employees **not enrolled** under your group coverage, please provide the number of employees included within each of the following categories:

Has No Coverage	_____	Christian Scientist	_____
Individual Coverage (Non-Group)	_____	Indian Health Service	_____
Medicare/Medicaid/OMIP/OHP	_____	Probationary Period	_____
Has Other Group Coverage	_____	Contracted Employees	_____
Tri-Care	_____	Insufficient Hours	_____

6. In addition to Regence BlueCross BlueShield of Oregon, do you offer other group health benefits to your employees? If yes, please indicate the carrier's name and type of coverage

7. Federal Tax Number _____

8. Would you like to see a life or disability proposal from Regence Life and Health? ____ Yes ____ No

To the best of my knowledge, I certify that all the information contained herein is correct. I understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted and that additional information may be required to verify eligibility of the group.

Signature _____ Title _____ Date _____

Print Name _____ E-Mail Address _____

Required for both new group quotes or at plan renewal