



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

Regence BlueCross BlueShield of Oregon
Underwriting, MS E8A
100 SW Market Street
PO Box 1271
Portland, OR 97207-1271

OFFICE USE ONLY
Rating Pool
% of Participation
Name
Date

Rep # Renewal Date Adv Notice

Business Name:
Attn:
Mailing Address:
City, State, ZIP Code:

Regence BlueCross BlueShield of Oregon Group Number

In order to renew your group's coverage options with Regence BlueCross BlueShield of Oregon, it is necessary for us to ask you to provide us with information so that we can satisfy state and federal insurance regulations applicable to small groups. Please complete and return this form in the enclosed postage-paid envelope no later than 14 days from the date of this letter. We are unable to renew your group's healthcare insurance coverage without this information.

Group eligibility is based on group size, which is determined by the average count of the total number of employees who were on your group's payroll and those individuals that were employed by an affiliated company during the previous calendar year. Groups that were not in business during the previous calendar year would base their group size on the current calendar year. The term "employee" means any individual employed by an employer. Contracted 1099 individuals are not included.

Based on the above, please complete the following:

- 1. Employee Count - Please enter the average number of employees that were employed during the previous calendar year. Your Employee Count should include: employees from any affiliated company, business owners, corporate officers, full-time, part-time, partners, seasonal, union employees and employees that work outside the State of Washington. Your Employee Count should not include contracted (1099) individuals.
2. Group Eligibility - Will you employ at least 1 employee on the intended effective date that your healthcare coverage renews?
3. Affiliated Company(s) - Is your company affiliated with any other company?
4. Group Headquarters - Is your company headquarters outside the state of Washington?

If Yes*, please identify where your Group headquarters is located:

State (if in the USA) OR Country (if outside the USA)

Continue To Next Page

Please answer the following questions:

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

Employee: 100% 75% 50% Other _____

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

6. How many hours per week do you require for health plan enrollment? _____

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

Currently enrolled employees (on your monthly billing statement) _____

COBRA/Washington continuation _____

Employees enrolled as a spouse of another employee _____

8. Of those employees **not enrolled** under your group coverage, please provide the number of employees included within each of the following categories. Eligibility hours are determined by the group in question 6. Please count each employee only once.

Has no coverage & meets eligibility hours _____ Christian Scientist _____

Individual coverage (Non-Group) & meets eligibility hours _____ Indian Health Service _____

Medicaid _____ Probationary Period _____

Has other group coverage _____ Insufficient hours for coverage _____


Tri-Care _____ Medicare _____

Publicly Sponsored or Subsidized Health Plan/BHP _____

9. 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:

10. Federal Tax Number _____

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 _____ Phone Number _____

E-Mail Address _____