



**Regence
BlueCross BlueShield
of Oregon**

An Independent Licensee of the Blue Cross and Blue Shield Association

Date: **Renewal Date:** **Advance Notice:**

Group Name
Attn:
Address
City, State, Zip

Regence BlueCross BlueShield Group Number: _____

Group Size Certification

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 2 employees on the intended effective date that your healthcare coverage renews? **No** **Yes**
3. **Affiliated Company(s)** – Is your company affiliated with any other company? **No** **Yes**
4. **Group Headquarters** - Is your company headquartered outside the state of Washington? **No** **Yes (*)**
 (*) If Yes, please identify where your Group is headquartered:

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

5. 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 _____

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

Currently enrolled employees (on your monthly billing statement) _____

COBRA/WA Continuation _____

Employees enrolled as a spouse of another employee _____

7. 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	_____
Medicaid	_____	Probationary Period	_____
Has Other Group Coverage	_____	Contracted Employees	_____
Tri-Care	_____	Insufficient Hours	_____
Publicly Sponsored or Subsidized	_____	Medicare	_____
Health Plan/BHP	_____		

8. 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. _____

9. Federal Tax Number _____

10. Would you like to see a life or disability proposal from Regence Life and Health? ___Yes ___ No

X _____, _____ / / _____
 SIGNATURE OF EMPLOYER OR ADMINISTRATOR TITLE DATE

Please retain a copy for your records and return this form in the enclosed postage-paid envelope, thank you!