



Regence

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 97207-1271

Group Master Application - For Group Size 2-99

Please complete and submit this application to our office **no later than 15 days prior to the effective date** or there may be delays to the processing and activation of your group. If additional space is needed, please attach a separate sheet of paper.

NEW/RENEWAL COVERAGE FOR GROUPS OF 2-99

Requested Effective Date _____

SECTION 1 - GROUP INFORMATION					
Group's Legal Name			Company Structure Sole Proprietorship Corporation Partnership Other _____		
Doing Business As (DBA)		Name to be used by Regence Legal DBA		Location of Business Headquarters	
Employer Federal (EIN) and State (if applicable) Tax ID Numbers			SIC Code and Industry Description 		
Name and Title of President, Owner, CEO			Group's Primary Language (if other than English)		
Physical Business Address Required (No PO Box or PMB)			Mailing Address (if different from Physical Business Address)		
City, State and ZIP Code			City, State and ZIP Code		
County		Phone Number () Fax Number ()		County	
				Phone Number () Fax Number ()	
PRIMARY GROUP CONTACT					
Name (First, MI, Last)			Title		
Phone Number ()		Fax Number ()		E-mail Address	
GROUP ADMINISTRATOR (if different from primary contact)					
Name (First, MI, Last)			Title		
Phone Number ()		Fax Number ()		E-mail Address	
OTHER CARRIER INFORMATION					
MEDICAL: Does your group have current Medical coverage? No Yes If yes, name of carrier _____ Date coverage will end _____			WORKERS' COMPENSATION: Does your group have Workers' Compensation coverage? No Yes If yes, name of carrier _____		
PHARMACY: Does your group have current Pharmacy coverage? No Yes If yes, name of carrier _____ Date coverage will end _____			DENTAL: Does your group have current Dental coverage? No Yes If yes, name of carrier _____ Date coverage will end _____		
Will you be offering more than one medical insurance carrier to your employees? No Yes * Name of Carrier(s) _____ <i>* This option is not allowed in all instances.</i>			Will you be offering more than one dental insurance carrier to your employees? No Yes * Name of Carrier(s) _____ <i>* This option is not allowed in all instances.</i>		
PRODUCER (AGENT) INFORMATION					
Agency Name			Producer's (Agent) Name		
Producer's E-mail Address		Producer's Phone Number		Producer's Number	
Secondary Producer's Name (if applicable)		Secondary Producer's Phone Number		Secondary Producer's Number	
For groups 51-99, please enter amount of medical commission _____ %		Commission Split: Producer #1 _____ %		Producer #2 _____ %	
For groups 51-99, please enter amount of dental commission _____ %		Commission Split: Producer #1 _____ %		Producer #2 _____ %	



SECTION 1 - GROUP INFORMATION (continued)

BILLING

Please select desired billing location: Physical Mailing Other (Please indicate any differences to page one in spaces below)	Do you require separate billing invoices by location? No Yes (If yes, please complete Additional Billing Location section(s) below)
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Business Name	Additional Billing Location Business Name	Additional Billing Location Business Name
Billing Address	Billing Address	Billing Address
City, State and ZIP Code	City, State and ZIP Code	City, State and ZIP Code
Phone Number () Fax Number ()	Phone Number () Fax Number ()	Phone Number () Fax Number ()
Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)
Payment Type	Payment Type	Payment Type
Pay by Check Surepay (EFT)* <i>* Please submit Surepay document</i>	Pay by Check Surepay (EFT)* <i>* Please submit Surepay document</i>	Pay by Check Surepay (EFT)* <i>* Please submit Surepay document</i>

EMPLOYER CENTER

Online Enrollment and eBilling No Yes*

*Primary Group Administrator for Employer Center: Name (First, MI, Last)	E-mail Address	Phone Number ()
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If more than two Secondary Group Administrators for Employer Center are required, indicate the number desired _____

For Online Enrollment, complete the following:
 Allow employees to enroll themselves and update family information online No Yes
 If Yes, allow employees to change their address online No Yes

FEDERAL MANDATES

COBRA:
 Group subject to COBRA? No Yes
 COBRA applies to employer groups that have employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year (January – December), with the exception of federal government plans and church plans. To the degree permitted by those laws, part-time employees may be counted as a fraction of a full-time employee.

OBRA:
 Group subject to OBRA? No Yes
 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? No Yes
 If you employed 20 or more full-time and/or part-time employees during each of the 20 calendar weeks in the current or preceding calendar year (January - December) you are subject to federal TEFRA/DEFRA laws.

ERISA:
 Group subject to ERISA? No Yes
 Is your plan year different than your renewal date? No Yes, list date _____
 Virtually all health plans of employers of any size (except church entities and government entities) are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA). This federal law sets minimum standards for the protection of individuals covered by a health plan subject to ERISA, as well as most voluntarily established pension plans.

Schedule A / Form 5500 information required?
 No Yes If yes, reporting time frame required _____



SECTION 2 - ELIGIBILITY INFORMATION

GROUP ELIGIBILITY (for purposes of determining group classification)

Note: An "eligible employee" is defined as an employee who on a full-time basis worked 17.5 or more hours per week.

1. Average number of employees in the preceding calendar year: _____ If less than two, indicate year business started: _____
2. Current number of eligible employees: _____
3. Do you have eligible employees employed outside the State? No Yes If yes, please indicate below.
Note: Group members who reside in the state of Hawaii are not eligible for coverage.
4. Do you file consolidated taxes? No Yes If yes, please explain _____

Number of Employees Out of State	State 1	State 2	State 3	State 4	State 5	State 6
State						
Employee Count						

EMPLOYEE ELIGIBILITY (for purposes of determining who is eligible for group benefits)

Note: The employer may determine the hours worked for eligibility between 17.5 and 40 hours/week.

1. This plan covers employees working the minimum number of hours required for coverage.
 The minimum number of hours to be eligible for coverage are: _____
- 2A. This plan covers the following: Employees and Dependents (incl. Oregon-Certified Domestic Partners) Employee Only (**No dependent coverage**)
- 2B. This plan provides coverage for Non-Certified Domestic Partners: No Yes

3. Probationary Periods: Groups of 51 or more may list employees in different classifications (e.g. hourly, salaried) for the purpose of offering different probationary periods to each employee classification. If you have chosen to do this, describe each job classification below. All employees must be accounted for. (If there are no classes, please enter all information in space provided for Class 1).	Actual Date of Hire (Group size 51-99 only)	DAYS (Maximum of 90 days allowed for Groups 2-50)						
		Coverage is effective on the first of the month following (please place an X in the appropriate box below)						
		*Date of hire	30	60	90	120	180	365
Class 1:								
Class 2:								
Class 3:								

- 3A. *Choose how Date of Hire (DOH) will be administered:
 Effective date will always be 1st of the month following DOH, even if DOH is the 1st of the month.
 Effective date will be 1st of the month following DOH, with the exception of when the DOH is the 1st of the month.
- 3B. Is probationary period waived on group's initial enrollment: No Yes
- 3C. For employees transferring from part-time to full-time status, the probationary period specified above should apply:
 Beginning on the date transferred to full-time status Retroactive to the original date of hire



SECTION 3 - EMPLOYER CONTRIBUTION

The employer will pay the following percentages toward the monthly rate. If different classes are chosen, please indicate classes and contribution for each.

Note: There is a minimum employer contribution percentage of 50% towards the employee coverage. There is no minimum employer contribution percentage for dependents.

	Class 1		Class 2		Class 3	
	Medical	Dental	Medical	Dental	Medical	Dental
Employee	%	%	%	%	%	%
Dependent	%	%	%	%	%	%

SECTION 4 - GROUP PARTICIPATION

Note: For groups of three or less eligible employees, 100% of eligible employees must be enrolled under this contract after valid waivers. For groups with more than three eligible employees, 75% of eligible employees must be enrolled under this contract after valid waivers.

1. Total number of employees on payroll regardless of hours worked (Do not include COBRA participants).
2. Less individuals not eligible for coverage on this plan:
 - a) Employees working fewer than the minimum hours described in Section 2 Eligibility Information including those who are part-time.
 - b) Employees who are temporary, seasonal or substitute employees.
 - c) Employees who are fulfilling their New Hire Probationary Period described in Section 2 Eligibility Information.
 - d) Individuals paid via IRS Form 1099.
3. Equals subtotal number of employees eligible to enroll.
4. Less number of employees completing waiver forms for **other qualifying coverage**.
5. Equals total number of employees eligible to enroll.
6. Number of employees completing a waiver form who are **declining coverage. (No other qualifying coverage)**.
7. Number of employee applications being submitted (for new groups only).
8. Number of former and current employees covered by your group under COBRA.
9. Number of former and current employees and/or their dependents who are currently eligible for COBRA but have not yet applied.
10. Number of former and current employees not eligible for COBRA who are covered by a group extension plan.

-	
-	
-	
-	
	=
Medical	Dental
-	-
=	=



SECTION 5 - BENEFITS AND RATES

MEDICAL - Please mark the benefits for the plan(s) you are purchasing. For renewing groups, please fill in the rate section.

If offered by class, specify Employee Classification _____

INNOVA - MEDICAL PLAN CHOICES

Upfront Office Visits			Upfront Office Visit Copay		
4 Visits	6 Visits	Unlimited Visits	\$20 / \$35 Copay	\$30 / \$45 Copay	\$40 / \$55 Copay
Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$250	\$2,000	90/70/70	\$2,000	\$5/\$25/\$50 OOP \$3,000	Vision
\$500	\$3,000	80/60/60	\$3,000	\$7/25%/50% OOP \$4,000	Employee Asst Program (EAP)
\$750	\$5,000	70/50/50	\$4,000	\$10/35%/50% OOP \$5,000	Complementary Care \$500 Maximum
\$1,000	\$7,500		\$6,000	\$10/\$35/\$75 No OOP	Complementary Care \$1,500 Maximum
\$1,500				\$0 Brand Deductible	
				\$250 Brand Deductible	
				\$500 Brand Deductible	
Rate Tier	Employee	Emp. + Spouse/Domestic Partner	Emp. + 1 Child	Family	Emp. + 2 + Children
Rates (for renewing groups only)					

ENGAGE - MEDICAL PLAN CHOICES

Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$0	\$2,000	80/80/80	\$2,000	\$5/\$25/\$50 OOP \$3,000	Vision
\$250	\$3,000	70/70/70	\$3,000	\$7/25%/50% OOP \$4,000	Employee Asst Program (EAP)
\$500	\$5,000	50/50/50	\$4,000	\$10/35%/50% OOP \$5,000	Complementary Care \$500 Maximum
\$1,000	\$7,500		\$6,000	\$10/\$35/\$75 No OOP	Complementary Care \$1,500 Maximum
				\$0 Brand Deductible	Preventive Care
				\$250 Brand Deductible	
				\$500 Brand Deductible	
Rate Tier	Employee	Emp. + Spouse/Domestic Partner	Emp. + 1 Child	Family	Emp. + 2 + Children
Rates (for renewing groups only)					

ACTIVATE - MEDICAL PLAN CHOICES

Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$1,500		80/60/60	\$3,000	\$5/25%/50% No OOP	Vision
\$2,000			\$4,000	\$7/30%/50% No OOP	Employee Asst Program (EAP)
\$3,000			\$6,000	\$10/\$35/\$75 No OOP	Complementary Care \$500 Maximum
				10%/30%/50% No OOP	Complementary Care \$1,500 Maximum
				\$250 Deductible	
				\$500 Deductible	
				\$1,000 Deductible	
Rate Tier	Employee	Emp. + Spouse/Domestic Partner	Emp. + 1 Child	Family	Emp. + 2 + Children
Rates (for renewing groups only)					

HSA HEALTHPLAN 2.0 - MEDICAL PLAN CHOICES

Deductible (includes Pharmacy)		Coinsurance Levels	Out of Pocket Maximum	Optional Benefits	
\$1,500 single/\$3,000 family	\$3,500 single/\$7,000 family	80/60/60	\$5,000/\$10,000	Vision	
\$2,500 single/\$5,000 family	\$5,000 single/\$10,000 family - 100% Coinsurance Only			Employee Asst Program (EAP)	
\$3,000 single/\$5,000 family (embedded family deductible)					
\$3,000 single/\$7,000 family (embedded family deductible)					
Rate Tier	Employee	Emp. + Spouse/Domestic Partner	Emp. + 1 Child	Family	Emp. + 2 + Children
Rates (for renewing groups only)					

Additional Information

Please continue making your selections on the next page.



SECTION 5 - BENEFITS AND RATES (continued)

MEDICAL - Please mark the benefits for the second plan you are purchasing. For renewing groups, please fill in the rate section.

Employee Classification - Please specify the additional classification if applicable _____
 Dual Option - Please refer to the Oregon Dual Option Matrix or to the Oregon Dual Option Guidelines for associated rules for allowed product combinations.

INNOVA - MEDICAL PLAN CHOICES

Upfront Office Visits			Upfront Office Visit Copay		
4 Visits	6 Visits	Unlimited Visits	\$20 / \$35 Copay	\$30 / \$45 Copay	\$40 / \$55 Copay
Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$250	\$2,000	90/70/70	\$2,000	\$5/\$25/\$50 OOP \$3,000	Vision
\$500	\$3,000	80/60/60	\$3,000	\$7/25%/50% OOP \$4,000	Employee Asst Program (EAP)
\$750	\$5,000	70/50/50	\$4,000	\$10/35%/50% OOP \$5,000	Complementary Care \$500 Maximum
\$1,000	\$7,500		\$6,000	\$10/\$35/\$75 No OOP	Complementary Care \$1,500 Maximum
\$1,500				\$0 Brand Deductible	
				\$250 Brand Deductible	
				\$500 Brand Deductible	
Rate Tier	Employee	Emp. + Spouse/Domestic Partner	Emp. + 1 Child	Family	Emp. + 2 + Children
Rates (for renewing groups only)					

ENGAGE - MEDICAL PLAN CHOICES

Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$0	\$2,000	80/80/80	\$2,000	\$5/\$25/\$50 OOP \$3,000	Vision
\$250	\$3,000	70/70/70	\$3,000	\$7/25%/50% OOP \$4,000	Employee Asst Program (EAP)
\$500	\$5,000	50/50/50	\$4,000	\$10/35%/50% OOP \$5,000	Complementary Care \$500 Maximum
\$1,000	\$7,500		\$6,000	\$10/\$35/\$75 No OOP	Complementary Care \$1,500 Maximum
				\$0 Brand Deductible	Preventive Care
				\$250 Brand Deductible	
				\$500 Brand Deductible	
Rate Tier	Employee	Emp. + Spouse/Domestic Partner	Emp. + 1 Child	Family	Emp. + 2 + Children
Rates (for renewing groups only)					

ACTIVATE - MEDICAL PLAN CHOICES

Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$1,500		80/60/60	\$3,000	\$5/25%/50% No OOP	Vision
\$2,000			\$4,000	\$7/30%/50% No OOP	Employee Asst Program (EAP)
\$3,000			\$6,000	\$10/\$35/\$75 No OOP	Complementary Care \$500 Maximum
				10%/30%/50% No OOP	Complementary Care \$1,500 Maximum
				\$250 Deductible	
				\$500 Deductible	
				\$1,000 Deductible	
Rate Tier	Employee	Emp. + Spouse/Domestic Partner	Emp. + 1 Child	Family	Emp. + 2 + Children
Rates (for renewing groups only)					

HSA HEALTHPLAN 2.0 - MEDICAL PLAN CHOICES

Deductible (includes Pharmacy)		Coinsurance Levels	Out of Pocket Maximum	Optional Benefits	
\$1,500 single/\$3,000 family	\$3,500 single/\$7,000 family	80/60/60	\$5,000/\$10,000	Vision	
\$2,500 single/\$5,000 family	\$5,000 single/\$10,000 family - 100% Coinsurance Only			Employee Asst Program (EAP)	
\$3,000 single/\$5,000 family (embedded family deductible)					
\$3,000 single/\$7,000 family (embedded family deductible)					
Rate Tier	Employee	Emp. + Spouse/Domestic Partner	Emp. + 1 Child	Family	Emp. + 2 + Children
Rates (for renewing groups only)					

Additional Information

Please continue making your selections on the next page.



SECTION 5 - BENEFITS AND RATES (continued)

DENTAL - Please mark the benefits for the plan(s) you are purchasing. For renewing groups, please fill in rate section.

If offered by class, specify Employee Classification _____

DENTAL PLAN CHOICES

Deductible and Annual Maximum

Encore 80/50/0	\$0 Deductible Classes I - II; \$500 Annual Maximum		\$25 Deductible Classes I - II; \$750 Annual Maximum		
	\$50 Deductible Classes I - II; \$500 Annual Maximum		\$50 Deductible Classes I - II; \$750 Annual Maximum		
Radiance 100/80/50	\$25 Deductible Classes I - III; \$1,000 Annual Maximum		\$75 Deductible Classes I - III; \$1,000 Annual Maximum		
	\$50 Deductible Classes I - III; \$1,000 Annual Maximum		\$75 Deductible Classes I - III; \$1,500 Annual Maximum		
Expressions 100/80/50	\$25 Deductible Classes II - III; \$1,000 Annual Maximum		\$50 Deductible Classes II - III; \$1,500 Annual Maximum		
	\$50 Deductible Classes II - III; \$1,000 Annual Maximum		\$25 Deductible Classes II - III; \$2,000 Annual Maximum		
	\$25 Deductible Classes II - III; \$1,500 Annual Maximum		\$50 Deductible Classes II - III; \$2,000 Annual Maximum		
Optional Benefits	Orthodontia (Available with Radiance and Expressions Plans with 26 or more enrolled employees)				
			\$1,000	\$1,500	
Rate Tier	Employee	Emp. + Spouse/Domestic Partner	Emp. + 1 Child	Family	Emp. + 2 + Children
Rates (for renewing groups only)					

DENTAL - Please mark the benefits for the second employee classification you are purchasing. For renewing groups, please fill in the rate section.

Offered to Employee Classification _____

DENTAL PLAN CHOICES

Deductible and Annual Maximum

Encore 80/50/0	\$0 Deductible Classes I - II; \$500 Annual Maximum		\$25 Deductible Classes I - II; \$750 Annual Maximum		
	\$50 Deductible Classes I - II; \$500 Annual Maximum		\$50 Deductible Classes I - II; \$750 Annual Maximum		
Radiance 100/80/50	\$25 Deductible Classes I - III; \$1,000 Annual Maximum		\$75 Deductible Classes I - III; \$1,000 Annual Maximum		
	\$50 Deductible Classes I - III; \$1,000 Annual Maximum		\$75 Deductible Classes I - III; \$1,500 Annual Maximum		
Expressions 100/80/50	\$25 Deductible Classes II - III; \$1,000 Annual Maximum		\$50 Deductible Classes II - III; \$1,500 Annual Maximum		
	\$50 Deductible Classes II - III; \$1,000 Annual Maximum		\$25 Deductible Classes II - III; \$2,000 Annual Maximum		
	\$25 Deductible Classes II - III; \$1,500 Annual Maximum		\$50 Deductible Classes II - III; \$2,000 Annual Maximum		
Optional Benefits	Orthodontia (Available with Radiance and Expressions Plans with 26 or more enrolled employees)				
			\$1,000	\$1,500	
Rate Tier	Employee	Emp. + Spouse/Domestic Partner	Emp. + 1 Child	Family	Emp. + 2 + Children
Rates (for renewing groups only)					

BASIC OREGON PLAN (Groups of 2 - 50 Employees)

To indicate a purchase of the Basic Oregon Plan for your group of 2 - 50 employees, please use our **Application for Group Coverage/Contract Change Form** in lieu of this form.



SECTION 6 - ACKNOWLEDGEMENTS AND CERTIFICATIONS

If you have any questions about the benefits and services that are covered, provided, limited or excluded under the group coverage(s) to which this application applies, please contact your Sales Representative before signing this application.

Note: The Company as used here means the group applying for coverage as indicated in Section 1 of this application.

I certify that I am an officer or employee of the Company, that I am duly authorized to execute this application on behalf of the Company, and that the Company:

- a) Applies for the group coverage(s) selected in Section 5 of this Group Master Application.
- b) Authorizes any person or other entity to release to Regence BlueCross BlueShield of Oregon any information requested by Regence BlueCross BlueShield of Oregon in connection with this application's processing.
- c) Acknowledges, where permitted by law, that Regence BlueCross BlueShield of Oregon may choose not to approve this application and any premium deposit will be returned if the application for group coverage(s) is not approved.
- d) Acknowledges that coverage is not in effect until Regence BlueCross BlueShield of Oregon accepts this application, establishes an effective date of coverage and issues the group contract(s) to the Company.
- e) Acknowledges that, if it is approved by Regence BlueCross BlueShield of Oregon, this application will form a part of the group contract(s) issued by Regence BlueCross BlueShield of Oregon and agrees that the Company will be bound by the terms and the conditions of entire group contract(s).
- f) Acknowledges that eligibility standards (e.g., waiting period, minimum hours, etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents.
- g) Acknowledges that it has selected the group coverage(s) to be offered to its employees, that its selection of this group coverage(s) was based upon written information provided by Regence BlueCross BlueShield of Oregon, and that no broker, agent, or consultant was or is authorized to modify the terms of the offer or to agree to changes. All material terms of coverage are set forth in the group contract(s), of which this application, if accepted, is but one part.
- h) Agrees to make payroll and other records directly related to employee participation levels or to employees' coverage, premiums, or contributions under the group contract(s) available to Regence BlueCross BlueShield of Oregon for inspection. This provision shall survive the termination of the group contract(s). Upon renewal or anytime throughout the contract period, the Company agrees to provide Regence BlueCross BlueShield of Oregon, upon its request verifications of employee participation levels.
- i) Agrees that, except with regard to a statutory continuation of coverage or unless the change is approved in writing by an authorized representative of Regence BlueCross BlueShield of Oregon, at no time shall any employee be permitted or required to make contributions for coverage at a rate higher than the employee contribution rate represented herein.
- j) Agrees the group contract(s) will determine the contractual provisions, including procedures, exclusions, and limitations, relating to the coverage and will govern in the event of conflict with any benefits comparison, summary, or other description of the coverage.
- k) Agrees to deliver, or otherwise make available to enrollees, all Regence BlueCross BlueShield of Oregon paper or online member documents and other coverage-related materials upon request by Regence BlueCross BlueShield of Oregon.
- l) Agrees to make all coverage options available to all eligible employees and dependents who satisfy eligibility requirements.
- m) Acknowledges that benefits may be added or deleted only at the time of initial application, at contract renewal, when required by law, or as mutually agreed between the Company and Regence BlueCross BlueShield of Oregon in accordance with the group contract(s).
- n) Acknowledges that Regence BlueCross BlueShield of Oregon must be notified (in the manner described in the group contract(s)) when there is a change to Company information (e.g., name, address, phone number, contact person, ownership status, etc).
- o) Acknowledges that contracting physicians, hospitals, and other health care providers are independent contractors and are neither agents nor employees of Regence BlueCross BlueShield of Oregon, that Regence BlueCross BlueShield of Oregon does not provide health care services, and that Regence BlueCross BlueShield of Oregon cannot guarantee any results or outcomes of care. We are responsible for the quality of health care you receive only as provided by law.
- p) Certifies under penalty of perjury that all statements made and information provided in this application are accurate and complete to the best of its knowledge or belief and acknowledges that Regence BlueCross BlueShield of Oregon will rely in part on the information in this application as the basis for Regence BlueCross BlueShield of Oregon's decision on whether to approve this application and issue any group contract(s). For the protection of all of Regence BlueCross BlueShield of Oregon's members, fraud or misrepresentation of material fact by the Company 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. In addition, Regence BlueCross BlueShield of Oregon will have the right to collect any claims payments or other damages. If Regence BlueCross BlueShield of Oregon continues a group contract with the Company after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Company no longer qualifies for the rate quoted, I understand that Regence BlueCross BlueShield of Oregon will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Company will be required to pay the rate adjustment within 30 days of the date of notice by Regence BlueCross BlueShield of Oregon.
- q) Agrees that any controversy or claim between the Company and Regence BlueCross BlueShield of Oregon arising out of or relating to the group contract(s), or the breach thereof, whether involving a claim in tort, contract, or otherwise, shall be subject to final resolution through binding arbitration. The Company and Regence BlueCross BlueShield of Oregon agree that the arbitrator's award shall be binding, may include an apportionment of attorney fees and other fees and costs, and may be enforced in any court with the requisite jurisdiction. Any such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association and in Multnomah County, Oregon (OR), unless mutually agreed otherwise by the parties. If any enrollee or former enrollee (or person claiming to be an enrollee or former enrollee) makes any claim or brings any action or proceeding arising out of or relating to the group contract(s) to which Regence BlueCross BlueShield of Oregon or the Company becomes a party, Regence BlueCross BlueShield of Oregon and the Company agree to cooperate in the defense of such claim, action, or proceeding and to resolve any controversy or claim between Regence BlueCross BlueShield of Oregon and the Company through arbitration under this paragraph only after the resolution of the enrollee's (or alleged enrollee's) claim.
- r) Appoints the agent of record indicated in Section 1 - Group Information (if any) to represent it in matters of group coverage benefits provided by Regence BlueCross BlueShield of Oregon. This appointment is in effect on the same day as the group coverage(s) and remains in force until rescinded in writing.
- s) Acknowledges that if the Company has an agent, that agent may receive bonuses, commissions, administrative services fees, or other compensation, including non-cash compensation from Regence BlueCross BlueShield of Oregon. Incentives may be based on any of several factors, including the size of the Company's business, the products the Company purchases, the agent's volume of business with Regence BlueCross BlueShield of Oregon, and other services the agent provides to the Company. These incentives may have an indirect impact on the Company's rates. For more information please contact the agent for the Company.

SIGNATURE

Group Authorized Signature



Official Title



Signature Date

