SHOP Participation Request Form

The purpose of this form is to provide company and health insurance policy information to the Marketplace, upon request, to determine eligibility for the Marketplace employer program.

THIS FORM MUST BE TYPED. HANDWRITTEN FORMS WILL NOT BE ACCEPTED.
MISSING INFORMATION OR BLANK FIELDS MAY LEAD TO A DELAY IN PROCESSING.

Requested effective date:		
COMPANY INFORMATION		
Company legal name:	Company DBA name:	
Address:		EIN
City:	State:	ZIP code:
Mailing address *(if different from above):*		
City:	State:	ZIP code:
Headquarters location: City:	State:	ZIP code:
Total number of eligible employees:		
PRIMARY CONTACT/SECONDARY CONTACT		
Primary contact name:	Title:	
Email address:	Phone #:	Fax #:
Secondary contact name:	Title:	
Email address:	Phone #:	Fax #:
AGENT INFORMATION		
Name:	Agent Oregon license #:	
Email address:	Phone #:	Fax #:

PLANS OFFERED TO EMPLOYEES

Enrolling in: ☐ Medical ☐ Dental **OR** ☐ Both

Carrier Name:	Plan Name:	Plan ID Number: (Refer to list of certified plans)

Carrier: E-mail the completed form to shop.marketplace@oregon.gov