

Date _____

Legal name _____ Industry Type _____

DBA _____ NAICS Code _____
(Enter if different than legal name)

Requested effective date _____

Previous Providence Health Plan group? Yes No If yes, previous PHP group # _____

<p>Contract contact _____</p> <p>Mailing address: _____</p> <p>City _____ State, ZIP _____</p> <p>Phone# _____ Fax# _____</p> <p>Email address _____</p> <p>Physical address: _____</p> <p>City _____ State, ZIP _____</p> <p>County _____</p>	<p>Billing contact _____</p> <p>Billing address: _____</p> <p>City _____ State, ZIP _____</p> <p>Phone# _____</p> <p>Email Address _____</p> <p>Business Fed Tax ID # (required) _____</p> <p>CMS group size* _____</p> <p><small>*CMS group size definition: The Centers for Medicare & Medicaid Services determine group size as the current total number of nationwide full-time employees, part-time employees, seasonal employees and partners. Do not count retirees, COBRA-qualified beneficiaries, individuals on other continuation options, or self-employed individuals who participate in the employer's group health plan.</small></p>
--	---

Subject to COBRA or State continuation **Dependents or students eligible to age 26.**

Minimum hours required per week (17.5 or more) _____ Employee-only contract*

Number of Benefit Eligible Employees _____ *By checking this box dependents are ineligible to enroll during the 12 month contract

The employer must contribute a minimum of 50% to the employee only rate of the least expensive plan offered to employees as required by law.

New Hire Eligibility

First of the month following: 30 days 60 days Date of hire

First of the month following date of hire. If hired on the first of the month, coverage is effective that day.

Day immediately following: 30 days 60 days 90 days

Date of hire

Waive probationary period at initial enrollment? Yes No

Previous carrier _____ Previous group # _____

Remarks: _____

Portland office: PO Box 4327
Portland, OR 97208-4327
Phone: 1-877-245-4077
Fax: 503-574-7543

Eugene office: 1500 Valley River Drive, Suite 200
Eugene, OR 97401
Phone: 1-877-245-4077
Fax: 800-889-8218

OREGON SMALL GROUP PLAN OPTIONS

Total Enhanced	
Total Enhanced 250 Platinum	
Total Enhanced 500 Platinum	
Total Enhanced 750 Platinum	
Total Enhanced 1000 Gold	
Total Enhanced 1500 Gold	
Total Enhanced 2500 Gold	
Total Enhanced 3500 Gold	
Total Enhanced 4500 Gold	
Total Enhanced 5500 Gold	
Total Enhanced 7000 Gold	

Balance <i>Indicate YES or NO: applying for Shop Credit</i>		
Balance 750 Gold	Yes	No
Balance 1500 Gold	Yes	No
Balance 2500 Gold	Yes	No
Balance 4000 Silver	Yes	No
Balance 6000 Silver	Yes	No
Balance 8000 Bronze	Yes	No

Standard <i>Indicate YES or NO: applying for Shop Credit</i>		
Providence Oregon Standard Gold	Yes	No
Providence Oregon Standard Silver	Yes	No
Providence Oregon Standard Bronze	Yes	No

Dental* <i>Dental enrollment & eligibility must match medical enrollment</i>	
Providence Essential Dental	
Providence Essential Access Dental	
Providence Advantage Access Dental	
Providence Preventive Dental	

Connect <i>Indicate YES or NO: applying for Shop Credit</i>		
Connect 750 Gold	Yes	No
Connect 1500 Gold	Yes	No
Connect 2500 Gold	Yes	No
Connect 4000 Silver	Yes	No
Connect 6000 Silver	Yes	No
Connect 6800 Silver	Yes	No
Connect 9100 Bronze	Yes	No

HSA Qualified <i>Indicate YES or NO: applying for Shop Credit</i>		
HSA Qualified 1500 Gold	Yes	No
HSA Qualified 2500 Silver	Yes	No
HSA E Qualified 3500 Silver	Yes	No
HSA E Qualified 5000 Bronze	Yes	No
HSA E Qualified 6000 Bronze	Yes	No
HSA E Qualified 7050 Bronze	Yes	No

Choice <i>Indicate YES or NO: applying for Shop Credit</i>		
Choice 750 Gold	Yes	No
Choice 1500 Gold	Yes	No
Choice 2500 Gold	Yes	No
Choice 4000 Silver	Yes	No
Choice 6000 Silver	Yes	No
Choice 6800 Silver	Yes	No
Choice 9100 Bronze	Yes	No

Domestic Partner	
Domestic Partner Plus	

CDHP Accounts – The following integrated accounts are serviced by HealthEquity			
Health Savings Account (HSA) <i>Can be paired with any HSA Qualified plan: no charge</i>	Flexible Spending Account (FSA) <i>Can be paired with any non-HSA plan</i>		
Health Reimbursement Account (HRA) <i>Can be paired with any non-HSA plan</i>	Limited Purpose Flexible Spending Account (LPFSA) <i>Can be paired with a HSA for dental and vision care</i>		

***Pediatric Dental Disclaimer:** Some of our medical plan options DO NOT include pediatric dental coverage. Under the healthcare reform law (the Affordable Care Act or ACA), if you purchase our medical coverage outside of the Exchange, we must have reasonable assurance that you have obtained separate pediatric dental coverage through an Exchange-certified pediatric dental plan. This requirement applies whether you obtain coverage for children or adults. Exchange-certified pediatric dental plans can be found through the Federally Facilitated Marketplace, www.healthcare.gov. If you purchase a PHP Standard medical plan, adding the Providence Dental Plan for children aged 18 and younger does not satisfy the ACA pediatric dental Essential Health Benefit (EHB) requirement.

PROVIDENCE USE ONLY							
		Medical Premium Totals			Dental Premium Totals		
Tier	Plan 1	Plan 2	Plan 3	Tier			
S				S			
SS				SS			
SC				SC			
SSC				SSC			
Account Executive			Check \$		Eligible		
Service Specialist			Check #		Subscribers		
Group #			Total Premium \$		Members		

Portland office: PO Box 4327
Portland, OR 97208-4327
Phone: 1-877-245-4077
503-574-7543

Eugene office: 1500 Valley River Drive, Suite 200
Eugene, OR 97401
Phone: 1-877-245-4077
Fax: 800-889-8218

PRODUCER INFORMATION

Producer _____ Commission schedule *applies to medical & dental* = PMPM

Firm _____ Phone _____ National Producer Number# _____

Full address _____

Original contract will be mailed to the group; a copy will be mailed to the Producer.

PRODUCER STATEMENT

I certify that all the information contained in this application is correct to the best of my knowledge. I also certify that:

1. This firm is a bona fide business meeting the definition of Oregon Small Employer and/or a small employer as defined by HIPAA and complies with Providence Health Plan underwriting requirements for small employers.
2. All participation requirements have been met.
3. Coverage(s), enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the employer.

Dated this _____ day of _____, 20 _____

Print name and title

Producer signature

EMPLOYER STATEMENT

1. We wish to apply to enroll our firm as a group with Providence Health Plan. We understand payment of premium will be deemed to be assent to all terms of the group contract, including modifications and renewals that are sent to us.
2. We understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted.
3. Minimum participation requirements for specific coverage(s) have been fully explained in detail, and we understand that they must be met and maintained in order for the group to remain eligible for coverage.
4. We understand the obligation to provide the Summary of Benefits and Coverage (SBC) to eligible employees at open enrollment and when newly eligible or newly hired, as required by the Patient Protection and Affordable Care Act and related regulations and rules, and accept responsibility for delivering the document.
5. We affirm that if we choose a medical plan without pediatric dental coverage, we will obtain pediatric dental coverage, as required by federal law, and that we will notify Providence Health Plan if we do not obtain coverage.
6. The broker/producer stated above is our Producer of record for Providence Health Plan and will remain such until this application is rescinded in writing.
7. To the best of our knowledge and belief, the foregoing statements are true and complete and, along with the group application, shall be the basis for the issuance of coverage under the group policy and shall become part thereof.
8. We understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company; and such intent to defraud may be subject to criminal and civil penalties and Providence Health Plan may cancel the group account and refuse to pay claims.
9. We understand that 30 days' notice is required to change this agreement.
10. We affirm that we are contributing a minimum of 50% of the employee only rate of the least expensive plan offered to employees, as required by law.

Dated this _____ day of _____, 20 _____

Print name and title

Authorized group signature

Portland office: PO Box 4327
Portland, OR 97208-4327
Phone: 1-877-245-4077
Fax: 503-574-7543

Eugene office: 1500 Valley River Drive, Suite 200
Eugene, OR 97401
Phone: 1-877-245-4077
Fax: 800-889-8218