



OREGON STANDARDIZED GROUP PROFILE FORM

This information must be collected for all new and renewing groups to determine whether the group qualifies as a small employer.

If you are requesting coverage as a single group because you are an affiliated group of employers for the purpose of pension plans under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, the carrier must treat the affiliated group as a single group and the affiliated group must fill out one group profile form. If you are an affiliated group of employers but are not requesting coverage as a single group, each employer group in the affiliated group must fill out a separate group profile form.

SECTION A

Group Legal Name:

Street Address:

City: _____ **State:** _____ **Zip:** _____

Company Headquarters (if different from above):

Group Contact Name:

Group Contact Email: _____ **Group Contact Phone #:** _____

SECTION B

EMPLOYEE ONLY PLAN? Yes No

EMPLOYEE + DEPENDENT PLAN? Yes No

1. Average number of employees during the preceding calendar year:
 If the average number of employees is 51 or greater, the group may qualify as a large group (see Section C for more information). If the average number of employees is at least 2 but not more than 50 during the preceding calendar year and you have at least 2 but not more than 50 eligible employees as of the date coverage is to take effect, you are a small employer.

2. Did more than 50% of the average number of employees work in Oregon during the preceding calendar year? Yes No

3. To determine if your group is subject to COBRA, indicate how many employees you employed on a typical business day in the previous calendar year:
 Do not count self-employed individuals, independent contractors, and members of the board of directors. (If the group had 20 or more employees during at least 50% of the previous calendar year, the plan qualifies for COBRA continuation.)

4. Number of *eligible* employees as of the date coverage is to take effect:
 This is the number of employees who work a regular schedule of 17.5 hours or more per week on the date coverage is to take effect. Eligible employees do not include employees who work on a temporary, seasonal or substitute basis.

5. Out of the number of eligible employees indicated in question #4, indicate the number of employees not eligible for coverage due to group's eligibility rules :

6. Total number of group eligible employees (#4 - #5) :

	Medical	Dental
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7. Out of the number of employees indicated in question #6, indicate the number of employees waiving due to other *group* coverage:
 Do not count the number of employees waiving for individual coverage here. Employees with individual coverage are counted as opting out in question # 9 below.

8. Total employee count (for participation requirement): (#6 - #7)

9. Out of the number of employees indicated in question #7, indicate the number of employees opting out of coverage:
 Count employees waiving for individual coverage as well as employees choosing not to take coverage here.

10. Total number of employees enrolling (#8 - #9)

11. Total number COBRA/State Continuation Enrollees (include primary insured's only):

12. Total number of employees and COBRA enrolling (#10 + #11) :

