



OREGON STANDARDIZED GROUP PROFILE FORM

This form must be completed for both new group quotes and at plan renewal.

This form must be used for all groups applying for group health insurance 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.

Group Legal Name:

Street Address:

City:

State:

Zip:

Company Headquarters (if different from above):

Group Contact Name:

Group Contact Email:

Group Contact Phone #:

EMPLOYEE ONLY PLAN?	<input type="checkbox"/> Yes <input type="checkbox"/> No
EMPLOYEE + DEPENDENT PLAN?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1. Average number of employees during the preceeding calendar year: If the total number of employees is 51 or greater, the group <u>may</u> qualify as a large group. If the average total number of employees is 50 or less during the preceding calendar year and you have at least two eligible employees as of the date coverage is to take effect, you are a small employer.	
2. Do more than 50% of employees work in Oregon?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Number of eligible employees as of the date coverage is to take effect: 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.	
4. Out of the number of eligible employees indicated in question #3, indicate the number of employees <u>not</u> eligible for coverage due to <u>group's eligibility rules</u> :	
5. Total number of group eligible employees (#3 - #4) :	
6. Out of the number of employees indicated in question #5, indicate the number of employees waiving due to other <u>group</u> coverage Do not count the number of employees waiving for individual coverage here. Employees with individual coverage are counted as opting out in question # 8 below.	
7. Total employee count (for participation requirement): (#5 - #6)	
8. 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.	
9. Total number of employees enrolling (#7 - #8)	
10. Do you intend to cover all employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. If no, do you intend to cover a <u>class or classes</u> ? Classes must be based on bona fide employment-based classifications consistent with your usual business practice. Employers with 25 or fewer eligible employees must cover all eligible employees.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments:

EMPLOYER CONTRIBUTION	
12. What percentage of premium is contributed by the employer?	
Employer Contribution for Employees (50% minimum)	
Employer Contribution for Dependents (no minimum)	

EMPLOYEE PARTICIPATION	
13. What percentage of <u>employees</u> participate in the medical plan? (#9 divided by #7)	
For groups of 2-4 employees, a minimum of 100% of eligible employees must participate. For groups of 5-50 employees, a minimum of 75% of eligible employees must participate.	

DEPENDENT PARTICIPATION	
If you checked "yes" to EMPLOYEE ONLY PLAN on page 1, please mark "N/A" for dependent participation in question #14 below. Please note that under an employee only contract, ODS would not allow any future dependents to be covered on this plan.	

If you checked "yes" to EMPLOYEE + DEPENDENT PLAN on page 1, but currently have no eligible dependents to enroll, please indicate 0% for dependent participation in question #14 below. Please note that under an employee + dependent contract, ODS will allow any future dependents to be covered on this plan.
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If you checked "yes" to EMPLOYEE + DEPENDENT PLAN on page 1, and currently have eligible dependents to enroll, please calculate your current dependent participation and indicate this percentage in question #14 below. Please note that under an employee + dependent contract, ODS will allow any future dependents to be covered on this plan.

14. What percentage of <u>dependents</u> participate in the medical plan?	%
For groups of 2-4 employees, a minimum of 100% of eligible dependents must participate. For groups of 5-50 employees, a minimum of 25% of eligible dependents must participate.	

Disclosure Notice for Employers

If an employer has more than 50 employees, the carrier may provide the employer a health insurance quote as a large group and must provide the quote upon request by the employer. However, the carrier must treat the employer as a small employer and must provide a quote on that basis if both of the following conditions apply:

- (1) The employer's workforce consists of at least two but not more than 50 eligible employees; and
- (2) Coverage is limited to eligible employees.

If an employer has no more than 25 eligible employees, the carrier must offer coverage to all eligible employees.

If an employer has 26 to 50 eligible employees, the carrier may limit coverage to the categories of employees established by the employer, but the categories must be based on bona fide employment-based classifications that are consistent with the employer's usual practice

Health insurance carriers are required to provide a small employer quote to any Oregon small employers upon request and must provide small employer coverage if an employer accepts that quote.

I am requesting a small employer quote for my group health plan _____(Initials)

To the best of my knowledge, I certify that all the information contained herein is correct. I understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted and that additional information may be required to verify eligibility of the group.

I am the: Group Administrator Business Owner Authorized Insurance Agent Other _____

Name (printed please)

Signature

Date:
