



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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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EMPLOYEE + DEPENDENT PLAN?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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1. Average number of employees during the preceding calendar year: If the average number of employees is 51 or greater, the group <i>may</i> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>eligible</i> 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 <i>not</i> eligible for coverage due to <i>group's eligibility rules</i> :			
6. Total number of group eligible employees (#4 - #5) :			
	Medical	Dental	
7. Out of the number of employees indicated in question #6, indicate the number of employees waiving due to other <i>group</i> 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) :			

13. What type of employees are you offering coverage to: a. All employees regardless of hours worked b. All employees working 17.5 hours or more per week c. All employees working the minimum hours required by your specific company in order to qualify for benefits (i.e. 40 hours per week) d. Only a certain classification of employees (i.e. Management only, Salaried only, etc.)* *If you chose "d" as the answer to this question, please explain in the comments below.		
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Comments:

EMPLOYEE PARTICIPATION	Medical	Dental
14. What percentage of <u>employees</u> participate in the plan(s)? (#10 divided by #8) 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 #16 below. Please note that under an employee only contract, ODS will 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 #16 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 #16 below. Please note that under an employee + dependent contract, ODS will allow any future dependents to be covered on this plan.

15. What percentage of <u>dependents</u> participate in the plan(s)?	%	%
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EMPLOYER CONTRIBUTION	Medical	Dental
16. What percentage of premium is contributed by the employer?		
Employer Contribution for Employees (50% minimum)		
Employer Contribution for Dependents (no minimum)		

SECTION C

Disclosure Notice for Employers

If an employer has an average of more than 50 employees during the preceding calendar year, the carrier may provide the employer a health insurance quote as a large group. However, the carrier must treat an employer as a small employer and must provide a quote only 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 as of the date coverage is to take effect; and
- (2) Coverage is limited to eligible employees.

Health insurance carriers are required to provide quotes and issue coverage to small employers pursuant to ORS 743.733 to ORS 743.737.

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:** _____