NEW GROUP APPLICATION

Welcome

Thank you for choosing ODS. Please complete the following pages.

For the group's initial set up, please provide the following:

- ☐ Group Application - Completed and signed by the Employer and the Agent
- ☐ Enrollment Forms all eligible employees - Please include the hire dates on all enrollment forms.
- ☐ Deductible Credit / Accumulator Report - If applicable
- ☐ EOS Service Agreement - Signed by the Employer
- ☐ Is Agent currently set up for online reporting (applicable for groups sized 100 or more)? - If not set up, submit a completed agent agreement form.
- ☐ ACH (automatic payment) Authorization Form - Signed, if applicable
- ☐ Last Month's Bill (Medical Only) - Required in order to waive pre-existing provisions. Claims may be placed on hold until the group's last month's bill has been received.
- ☐ First Month's Premium

  Dental Only Plan - Make check payable to ODS

  Medical or combined Medical and Dental Plans - Make check payable to ODS Health Plan, Inc.
- ☐ Completed Declination of Group Coverage Forms - If applicable

Member Handbooks

ODS encourages our members to view their handbooks online at www.odscompanies.com.

How many printed ODS member handbooks would you like? ______________

All new group enrollment materials must be received by ODS no later than the 20th of the month for a first of the following months effective date.

Large Employer Group Application (51+)

EFFECTIVE DATE:

TYPE:

GROUP INFORMATION:

Legal Name: ______

Billing Name: ______
(if different from Legal Name)

Street Address: ______ City/State/Zip: ______

Billing Address: ______ City/State/Zip: ______
(if different from street address)

Group Administrator: ______ Billing Contact: ______

Phone #: ______ Phone #: ______

Fax #: ______ Fax #: ______

E-mail Address: ______ E-mail Address: ______

Tax ID #: ______ ERISA Plan #: ______

Renewal Date: ______ Advance Renewal Notice (days): ______

Diary Month/Year: ______

ELIGIBILITY:

1. What percentage of the medical premium is to be contributed by the employer?
   For employees *(minimum 50%):* ______ For dependents: ______
2. What percentage of the dental premium is to be contributed by the employer?
   For employees *(minimum 50%):* ______ For dependents: ______
3. Can employees and their dependents enroll in an ODS dental plan without also enrolling in the group's medical plan, whether or not ODS is the medical carrier? ***(Y/N):*** ______
   (Yes = Standalone; No = Integrated)
4. How many hours per week must an employee work to be eligible for benefits? ______
   (minimum 17.5 per week):
5. Dependent age maximum: ______ Student age maximum: ______ Verified by: ______
6. What is the eligibility period an employee must complete before becoming eligible for benefits?
   The first of the month following: ______ **OR** ☐ Date of Hire with Mid Month Pro Rate
   Apply to all employees? ***(Y/N):*** ______ If no, describe:
7. When do changes made during open enrollment become effective? At renewal? ______ or date: ______
8. Is the group subject to ERISA (Employee Retirement Income Security Act of 1974)? ***(Y/N):*** ______
9. The Oregon Family Fairness Act requires a group to include the same enrollment rights for same sex Partners who are registered with the county, as it does for married couples. Your group will automatically be set up with this, unless you are an ERISA ASO group.

9a. If you are an ERISA ASO group, do you choose to include the Oregon Family Fairness Act? ***(Y/N)*** ______

9b. For all groups, (insured or ASO, ERISA or non-ERISA):
Is Domestic Partnership coverage available by affidavit? ***(Y/N)*** ______
(This is separate from registered Partners under Oregon Family Fairness Act)
If yes, do you cover: ☐ Opposite Sex ☐ Either Sex ☐ Same Sex

10. Does the group have a bargaining agreement (Union) in force? ***(Y/N):*** ______
    If yes, effective date: ______ Expiration date: ______
11. Does the group represent or belong to an association or trust? ***(Y/N):*** ______
    If yes, provide the date filed with the State as a group policyholder and the approval number:
    Date: ______ Approval #: ______
12. Will out of state employees (other than those in SW Washington) be covered by ODS?: ***(Y/N):*** ______
    If yes, list state (s) and number of employees in each: ______
13. What month does the group's fiscal year begin? ______

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

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 B 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**
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)* :		
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.**		

Comments:

EMPLOYEE PARTICIPATION	Medical	Dental
14. What percentage of *employees* participate in the plan(s)? *(#10 divided by #8)*		

DEPENDENT PARTICIPATION	Medical	Dental
15. What percentage of *dependents* participate in the plan(s)?	%	%

SECTION B

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:**

Types of Coverage:

Medical:		In-Network					Out-of-Network			Group Size
ODS Standard Plan Design #	Plan Type	Deductible	Co-ins. %	Co-pay	Hospital Co-pay	Out-of-Pocket	Ded	Co-ins. %	Out-of-Pocket	Large

Select all networks to be accessed: ☐ ODS Plus ☐ First Choice ☐ First Choice/HIN ☐ PHCS ☐ MHN

☐ Non-Standard/Negotiated Plan Design. Please note changes in *ITALICS* & **BOLD.** Modified from Plan #: ____________

☐ **GRANDFATHERED BENEFITS**

Pharmacy:	Retail			Mail Order			Retail & Mail Order - (Specify):			
ODS Standard Plan Design#	Generic Co-pay	Preferred Co-pay	Non-Preferred Co-pay	Generic Co-pay	Preferred Co-pay	Non-Preferred Co-pay	Ded	Benefit Max	Out-of-Pocket	Other

☐ Include ODS Enhanced Specialty Services

Contraceptive Coverage: ______ Type of Coverage: ____________ Diabetic Supplies: ____________

☐ Non-Standard/Negotiated Plan Design. Please note changes in *ITALICS* & **BOLD.** Modified from Plan #: ____________

☐ **GRANDFATHERED BENEFITS**

Vision:	
ODS Standard Plan Design #	Plan Type

☐ Non-Standard/Negotiated Plan. Please note changes in *ITALICS* & **BOLD.**

Modified from Plan #: ____________

Dental:	Group Size:			In-Network			Out-of-Network		
ODS Standard Plan Design#	Plan Type	Deductible	Maximum	Preventive	Basic	Major	Preventive	Basic	Major

☐ Non-Standard/Negotiated Plan Design. Please note changes in *ITALICS* & **BOLD.** Modified from Plan #: ____________

Orthodontia:	
ODS Standard Plan Design#	Plan Type

Other: ____________

☐ Non-Standard/Negotiated Plan Design. Please note changes in *ITALICS* & **BOLD.** Modified from Plan #: ____________

Direct Option:								
ODS Standard Plan Design#	Plan Type	Deductible	Maximum	Prev/ Diag	Surgical Extractions	Crowns	Other	Ortho

EXISTING COVERAGE:

1. Please provide the previous carrier(s) name and contact phone number:
   Medical: ____________ Dental: ____________
2. Please provide the name and contact phone number for the current insurance carrier(s), both medical and dental:
   Medical: ____________ Dental: ____________

3. If dual coverage is available, please list the other carrier(s):
   Medical: ____________ Dental: ____________

4. If this plan is replacing an existing plan, will members receive credit from the previous plan? ***(Y/N):*** ______
   If Yes, check the type(s) of report(s) below that will be available for applying credit:

   Medical deductible: ☐ Report ☐ Explanation of Benefits (EOB) ☐ Other: ____________
   Medical Out-of-pocket: ☐ Report ☐ Explanation of Benefits (EOB) ☐ Other: ____________
   Dental deductible: ☐ Report ☐ Explanation of Benefits (EOB) ☐ Other: ____________
   Accumulator Report: ☐ Medical ☐ Dental ☐ Ortho

5. If enrolling in Dental Plan A (incentive plan), will benefits for members who were covered under the group's prior plan begin at the first year benefit level? ***(Y/N):*** ______
   If No, check the benefit level that will apply to existing members: ☐ Current Level (Report needed)
   ☐ Percentage for all members (Report needed) ______ ☐ Accumulator Transfer

RATE INFORMATION - Insured

Funding Type:	
Rate Structure:	

Effective Date: ____________________ Ending Date: ____________________

RATES				
Employee Counts				
Medical rate				
RX Buy Up rate				
Vision rate				
Wellness Services rate				
SUBTOTAL MEDICAL *	**$0.00**	**$0.00**	**$0.00**	**$0.00**
ODS DentalEmployee Counts				
ODS Dental rate				
ODS Orthodontia rate				
SUBTOTAL ODS DENTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Direct Option Employee Counts				
Direct Option Dental rate				
SUBTOTAL DIRECT OPTION	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Subtotal	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL BILLED	**$0.00**	**$0.00**	**$0.00**	**$0.00**

*** Non-Standard -** Unhide & Use **Row 16** if Vision rates need to be broken out from Medical Rates on bill.

Rate Guarantee? ____________ **Estimated First Month's Premium:** **$0.00**

Payment Information:

Premium Payment Method	

If Payment Method is Automated Clearing House (ACH)

ACH initiated by:	
ACH frequency:	

Commission:

Agent Commission (Medical)	
Agent Commission (Dental)	
Agent Commission (Pharmacy)	
Agent Commission (Vision)	

RATE INFORMATION - Insured VOLUNTARY

Funding Type:	
Rate Structure:	**5 Tier**

Effective Date: ____________________ Ending Date: ____________________

RATES	**Emp Only**	**EE + SP**	**EE + Family**	**EE + Child**	**EE + Children**
Employee Counts					
Dental rate					
Orthodontia rate					
SUBTOTAL DENTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Direct Option Dental rate					
SUBTOTAL MATCH DENTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Subtotal	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL BILLED	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

* Indicate only if Vision rates should be broken out from Medical and Dental Rates on bill.

Rate Guarantee? __________ **Estimated First Month's Premium:** **$0.00**

Payment Information:

Premium Payment Method	

If Payment Method is Automated Clearing House (ACH)

ACH initiated by:	
ACH frequency:	

Commission:

Agent Commission (Medical)	
Agent Commission (Dental)	
Agent Commission (Pharmacy)	
Agent Commission (Vision)	

RATE INFORMATION - ASO

Effective Date: ______________ Ending Date: ______________

RATES

		Amount:
Dental		
Administration:		
Commission:		
Total:		**$0.00**
Medical		
Administration:		
PPO Access Fee		
Commission:		
E-Doc & Nurseline:		
Free and Clear		
OMIP (groups in Oregon with Stop Loss only):		
Wellness Services:		
Other:		
Total:		**$0.00**
Stop Loss Contract Type:		
Specific Stop Loss Fee:		
Specific Level:		
Aggregate Stop Loss Fee:		
Aggregate Attachment Point:		
Aggregate Level:		
Minimum Aggregate Ded:		
Total Stop Loss Fees:		**$0.00**
Pharmacy		
Administration:		
Commission:		
Total:		**$0.00**
Vision		
Administration:		
Commission:		
Total :		**$0.00**

ASO Administration - Payment Information

ASO Admin Billing Method:	
If list bill, Admin will be paid by:	

ASO Claims - Payment Information

ACH Claims Frequency:						
ASO Claims Payment Method:						
Prefund Amount:	Medical:		Dental:		Rx/Vision:	

ASO Claims Billing

Contact Name:	
Address:	
Phone:	
Fax:	
Email:	

Utilization Report

Will report be sent with the bill or alone?	
Report style:	
Has PHI Agreement been submitted?	
How will group receive bill (mail, fax or email)?	
Frequency of Utilization Report:	

RATE INFORMATION - Minimum Premium

Rate Structure:		Effective Date:		Ending Date:	

RATES					**Total**
Employee Counts					**0**
Medical Min. Premium Rate					**$0.00**
Medical MCL Premium Rate					**$0.00**
Rx Min. Premium Rate					**$0.00**
Rx MCL Premium Rate					**$0.00**
Vision Min. Premium Rate					**$0.00**
Vision MCL Premium Rate					**$0.00**
SUBTOTAL MEDICAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Dental Min. Premium Rate					**$0.00**
Dental MCL Premium Rate					**$0.00**
Ortho Min. Premium Rate					**$0.00**
Orhto MCL Premium Rate					**$0.00**
SUBTOTAL DENTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL BILLED	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

* Indicate only if Vision rates should be broken out from Medical and Dental Rates on bill.

Misc. Information

Included in Minimum Premium rates above?

Specific SL level					
Reserves: Medical					
Reserves: RX					
Reserves: Vision					
Reserves: Dental					
Reserves: Orthodontia					
Agent Commission: Medical					
Agent Commission: Rx					
Agent Commission: Vision					
Agent Commission: Dental					
Agent Commission: Orthodontia					

Payment Information

Premium Payment Method	
*ACH initiated by	
ACH frequency	
Positive/Negative billing:	

***When ODS initiated, the ACH form must be attached.**

AGENT INFORMATION

AGENT 1	______________________	Tax ID #	______________
Agency	______________________	Phone #	______________
Comm Address	______________________	Fax #	______________
City/St/Zip	______________________	E-Mail ID	______________
Physical Address	______________________	License #	______________
City/St/Zip	______________________		

Split Commission Amount: ______________

*** For Tax purposes, please indicate if Tax ID or S/S #**

I hereby make application to ODS, on behalf of the Group, for the Group Policies indicated in this group application. I understand that there is no coverage in effect until ODS accepts this Application and premium deposit and establishes an effective date. If this Application is not accepted, the premium deposit will be refunded.

I hereby certify all eligible employees are enrolling in the selected Group Policies and all enrolling employees meet the eligibility requirements specified above.
In addition, I hereby appoint the above agent as our Agent of Record to represent us in matters of group insurance benefits provided by ODS. This appointment is in effect on the same day as this Policy and will remain in force until rescinded in writing.

For all medical plans that currently have a pre-existing exclusion period only:
In addition, I hereby acknowledge responsibility on behalf of the Group to provide the Initial Notice of HIPAA Special Enrollment Rights and Exclusion Periods to all employees.

X ____

Authorized Signature for **GROUP** — Authorized Signer's Title

____

Authorized Signer's Printed Name — Date

X ____

Authorized **AGENT** Signature

____

Authorized Agent's Printed Name — Date

X ____

Marketing Representative Signature — Date

EMPLOYER ONLINE SERVICES AGREEMENT

Oregon Dental Service and ODS Health Plan, Inc. ("ODS") and ______________________("CLIENT") are mutually interested in enhancing service to our members. Electronic Services are advanced technologies designed to allow a group administrator or person(s) designated by the same, to review and modify member enrollment and Primary Care Physician designations, order ID cards and perform other group enrollment related functions for the CLIENT's employees who are members of an ODS health benefit plan.

The parties agree as follows:

1. Description.

Electronic Services will consist of on line access to limited INFORMATION, the content solely determined by ODS, via a secure electronic connection.

2. Definitions.

a. INFORMATION is defined as benefit plan enrollment information regarding a member including, but not limited to, the member's name, address, phone number, family members, benefit levels, Primary Care Physician and eligibility. INFORMATION shall also include software applications that transmit individually identifiable information of a member.
b. Electronic Services include all ODS computer, telephonic, email or wireless services or systems.
c. Backup Materials are the electronic, written or printed materials through which CLIENT obtained the INFORMATION from its employees. Backup Materials include, but are not limited to, enrollment forms, benefit plan applications, personal data sheets, and any forms required to update or change INFORMATION, whether in written or electronic form.

3. Information.

The INFORMATION is the property of ODS. CLIENT agrees not to retransmit, disseminate, sell, distribute, publish, broadcast, circulate or commercially exploit the INFORMATION in any manner nor use the INFORMATION for any unlawful purpose. This applies to any individually identifiable information whether in electronic, written, printed or verbal form.

4. Confidentiality of Information

ODS and Client mutually acknowledge that security and confidentiality of member information, including but not limited to member demographic, health and claims information, are of extreme importance. Client shall maintain the security and confidentiality of such information as required by all applicable state and federal law and:

a. Client will not use or further disclose the information for any purpose except as necessary to carry out this agreement;
b. Client will use appropriate physical, technical and administrative safeguards to prevent use or disclosure of the information other than as provided for by this agreement.

5. Access, Passwords, and Security.

CLIENT agrees to follow the security and privacy protocols established by ODS and described in the Online Reference Documentation to ensure that all Electronic Services transactions are authorized and to protect all member-specific INFORMATION from improper access.

CLIENT will maintain confidentiality of logon identifications and passwords and prevent any unauthorized individual(s) from accessing Electronic Services and/or using INFORMATION in a manner contrary to this Agreement.

6. Reporting Violations.

CLIENT agrees to immediately notify ODS if CLIENT becomes aware of any of the following:
a. Any loss or theft of access codes or passwords.
b. Any unauthorized use of any access codes or passwords.
c. Any unauthorized use of the Electronic Services.
d. Any loss, theft or unauthorized use of INFORMATION.
e. Any loss or theft of hardware which contains INFORMATION.

CLIENT further agrees to make any and all reasonable efforts to correct or mitigate the effects of any such occurrences and to prevent reoccurrence.

7. Enrollment Materials.

CLIENT agrees to retain all Enrollment Materials, regardless of media, for a period of seven years and, upon request, to provide ODS with reasonable access to such Enrollment Materials.

Oregon Dental Service
Dental Insurance
–
ODS Health Plan, Inc.
Medical Insurance
–
The ODS Companies
ODS Tower
601 S.W. Second Ave.
Portland, OR 97204.3156
Phone: 503.228.6554
www.odscompanies.com

8. Indemnification.

CLIENT agrees to defend, indemnify and hold ODS harmless from and against any and all claims, losses, damages, liability, costs and expenses (including but not limited to defense costs and attorney fees) arising from CLIENT's violation of this Agreement, misuse of INFORMATION, or any third-party's rights, including violation of any proprietary right and invasion of any privacy rights. This obligation will survive the termination of this Agreement.

9. Termination.
ODS reserves the right to terminate CLIENT access to Electronic Services or any portion of the services in its sole discretion, without notice and without limitation, for any reason whatsoever, including but not limited to unauthorized use of CLIENT access codes or passwords, misuse or unauthorized use of INFORMATION, failure to adhere to policies set forth in documentation, or breach of this Agreement.

10. Assignment.

CLIENT may not assign its rights, interests or obligations or any part thereof under the Agreement without prior written permission of ODS.

11. Invalidity Due to Change in Law.

This Agreement shall be voidable by either party if it is prohibited by state or federal law or where ruled or adjudicated to be invalid, void or illegal under any current or future federal or state statute or regulation. If any portion of this Agreement is invalid due to such a prohibition, the remainder of the Agreement shall remain in effect. CLIENT agrees to modify the agreement to conform to changes in applicable rules designated by current or future federal or state statute or regulation, if requested by ODS.

12.Terms of Use

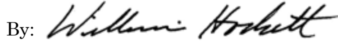
CLIENT also agrees to abide by the Terms of Use posted on the ODS Web site if using the Web site to access Electronic Services.

13. Entire Agreement.

This Agreement constitutes the entire agreement between the parties, which may be modified only in writing, signed by both parties. There are no promises or representations between the parties other than as stated in this Agreement.

14. Notices.

All notices will be effective when received in writing. Notices to CLIENT will be given at the address shown in this Agreement below, and notices to ODS will be given at 601 SW 2nd Avenue, Portland, OR 97204. Either party can give notice of address change.

By: 

William Hockett
Vice-President

15. Acknowledgment.

By signing this Agreement, CLIENT acknowledges that CLIENT has read, understands and accepts the terms and conditions as stated herein and in Electronic Services documentation.

____
Signature

The individual signing on behalf of the Client must be the owner of the business in a sole proprietorship, a partner in a partnership, or the designated principal in a limited partnership, corporation or other licensed entity. Examples include: Owner, Officer, Administrator, Human Resources Director.

____
Printed Name

____
Title

____
Date

____
Tax Identification #

____
Name of CLIENT

____
ODS Group Number

____
Name of Contact Person

The Contact Person is the person within the Client organization who is selected by the Client to authorize user access to Electronic Services.

____
Contact Telephone Number

____
Contact E-mail Address

How did you hear about Employer Online Services?
Website Marketing Representative Billing Specialist Other: ____________

Return the signed agreement to:
Employer Online Services Administrator
ODS Health Plans
PO Box 40384
Portland, OR 97240-0384
Fax 503-948-5577

Account Structure Worksheet

Billing

1. Are billing statements sent to multiple locations? (Y/N) ____________

1a. If yes, please list each location and their billing address:

2. Does the group use a TPA for COBRA or Retiree Administration? (Y/N) ____________

2a If yes, enter TPA name: ____________ Contact: ____________

Mail COBRA bill to: ____________

Phone: ____________

2b If no, will the group elect COBRA administration through BenefitHelp Solutions (BHS)? **(Y/N):**

ODS subsidiary, BenefitHelp Solutions (BHS), provides COBRA Administration at no additional cost to ODS Medical Groups. If electing to use BHS to administer your COBRA, mark Yes for question 2b.

Define Classifications:

I. ____________
II. ____________
III. ____________
IV. ____________
V. ____________
VI. ____________

Define Benefits:

Benefit 1 ____________
Benefit 2 ____________
Benefit 3 ____________
Benefit 4 ____________
Benefit 5 ____________
Benefit 6 ____________

Classification of EE	**I**	**II**	**III**	**IV**	**V**	**VI**
Do all employees have the same benefit options?						
Comments:						
Can employees choose between multiple product offerings? (i.e. dental, medical, rx etc)						
Comments:						
Are there specific reporting requirements for each classification of employee?						
Comments:						
Does the billing statement need to be sorted by classification of employee?						
Comments:						
Is the eligibility waiting period the same for each classification?						
Comments:						
Does each class use the network listed on page 3?						
Comments:						