*Health Net Health Plan of Oregon, Inc. (Health Net)*

Large Business Group

# Group Application

**(51+ EMPLOYEES)**

## Subscriber Group information

| | | |
|---|---|---|
| Full legal name of employer – hereafter known as Subscriber Group (include punctuation and abbreviations): | | Group number: |
| DBA: | Phone: | Fax: |
| Physical address (street address, city, state, ZIP): | | Effective date: |
| Billing address (if different than the above address): | | Anniversary date: |
| Subsidiary/affiliated companies and other employer locations: | | Federal tax ID/EIN: |
| Group benefits administrator name and title: | | Administrator telephone: |
| Group benefits administrator address: | | Administrator email address: |
| Billing contact name and title: | | Billing contact telephone: |
| Billing contact address: | | Billing contact email address: |
| COBRA administrator contact name and title: | | COBRA administrator contact telephone: |
| COBRA administrator contact address: | | COBRA administrator contact email address: |
| Workers' compensation carrier name: | | Policy number: |

## Type of organization

| | |
|---|---|
| ☐ Corporation ☐ Association *(as defined by ORS 743.522)** | Nature of business: |
| ☐ Sole proprietorship ☐ Trust *(as defined by ORS 743.522)** | Date of business inception: |
| ☐ Partnership ☐ Discretionary group *(as defined by ORS 743.522)** | SIC code: |
| ☐ Other (describe): ______ | |

***Is the association/trust/discretionary group filed and approved with the Division of Financial Regulation as a group policyholder?**

☐ Yes, current Division of Financial Regulation Approval #: ______

☐ No ☐ N/A

*(continued)*

## Type of organization (continued)

**Is the group subject to ERISA?** Generally, ERISA applies to all employer health plans. Sole proprietors or partnerships that do not have any employees may not be subject to ERISA. The Subscriber Group must notify Health Net as changes in ERISA status occur.

☐ Yes, ERISA plan year begins in the month of: ______________________________

☐ No, government or public plan or church plan

☐ No, other reason (please specify): ______________________________

## Eligibility information (This provision may only be changed at the time of the group contract renewal each year.)

Employees: Regular, active, full-time employees scheduled to work at least ________ hours/week (must be at least 17.5 hours)

☐ Dependents: Legal spouse, Registered Domestic Partner, and child(ren), from birth to age 26, of employee spouse or Registered Domestic Partner

Include non-registered domestic partners as dependents: ☐ Yes ☐ No

☐ Local government retirees

"Local government" means any city, county, school district, or other special district in this state.

"Retired employee" means a former officer or employee of a local government who is retired for service or disability, and who received or is receiving retirement benefits under the Public Employees Retirement System or any other retirement system or plan applicable to officers and employees of the local government.

Other classification, e.g., early retirees.

(Group size requirements apply. Must be approved by Underwriting.): ______________________________

## Employers' probationary period (Employees must enroll within 31 days of becoming eligible.)

Will there be eligibility conditions that will apply prior to the probationary period (e.g., being in an eligible job classification, achieving job-related licensure requirements or satisfying a "reasonable and bona fide employment-based orientation period")? ☐ Yes ☐ No

**Newly hired employees:**
First day of the month on or following: ☐ date of hire ☐ 30 days from date of hire ☐ 60 days from date of hire

**Newly eligible employees:** First day of the month following date of eligibility. ☐ Yes ☐ No

**Definition of "newly eligible employees" (check all that apply):**

☐ Part-time to regular, full-time employee. Specify number of hours: ______

☐ Rehired former employee. Rehired within ______ days or ______ months; cannot exceed 9 months. Employees terminated by reason of layoff are not subject to any waiting period if rehired within 9 months.

☐ Transfer

☐ Other (Must be pre-approved by Underwriting.): ______________________________

**Definition of "newly eligible dependents":**
For child: Date of birth or placement for adoption.

For spouse, Registered Domestic Partner and stepchild(ren): First day of the month on or following the date of marriage or certification of Registered Domestic Partner.

**Waive eligibility waiting period (for new groups only)**
Do you want to waive the eligibility waiting period for all current employees?

☐ Yes, all current employees will be eligible for benefits as of the effective date.

☐ No, current employees who have not completed the probationary period must finish serving the probationary period.

*(continued)*

## Coverage applied for – Please indicate name of plan chosen (for example, A15-250-2-4000)

☐ PPO:

☐ PPO HDHP Integrated HSA: ____________________

☐ PPO Integrated HRA: ____________________

Select one of the following for HRA:

☐ Option A ☐ Option B ☐ Option C

☐ Triple Option: ____________________

☐ EPO[1]: ____________________

☐ Prescription: ____________________

☐ Alternative Care buy-up: ____________________

☐ CommunityCare 1T: ____________________

☐ CommunityCare 3T: ____________________

☐ CommunityCare 1T HDHP: ____________________

☐ CommunityCare 3T HDHP: ____________________

☐ Dental: ____________________ ☐ Vision: ____________________

☐ Other riders:

## Monthly rates (including riders)

**Four-tier:**

☐ Employee: __________ ☐ Employee + spouse: __________ ☐ Employee + child(ren): __________

☐ Employee + family: __________

## Employer contribution (The employer must contribute at least 50% of the cost of employee coverage.)

Employee coverage: _______ % of monthly rate OR $ _______toward monthly rate

Dependent coverage: _______ % of monthly rate OR $ _______ toward monthly rate

### Additional details

### Participation requirements

Standard minimum participation and contribution requirements below apply unless modified in quote or renewal Underwriting assumptions. All enrolled employees must have a bona fide employee relationship with the Employer Group. If the employer requires employees to contribute to the employee-only premium, a minimum of 75% of all eligible employees must enroll in the plan. If more than one health plan is offered, Health Net's enrollment represents at least 38% of the eligible employee population. If employer contributes 100% of the employee premium, 100% of employees must enroll in the plan. A Refusal of Coverage/Waiver must be submitted for all employees and dependents declining coverage. The employer must contribute at least 50% of the cost of the employee coverage. Eligible employees must be regular, full-time employees. Failure to maintain these minimum contribution and minimum participation requirements may result in termination or nonrenewal.

[1]Exclusive Provider Organization.

*(continued)*

## Enrollment information

Due to Medicare Secondary Payor reporting requirements, enter the total number of worldwide employees employed by the company/ companies applying for coverage: __________

**Please note:** Federal regulations require you to promptly notify Health Net if the number of employees changes between the ranges of 0–19, 20–99, 100+.

Average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage: __________

An employee is defined as any person for whom the company issues a W-2, including full-time, part-time, and seasonal workers, and regardless of insurance eligibility.[2]

To calculate the average number of employees, determine the number of employees for each month, add each month's number to get an annual total and then divide by 12. Round up or down to the nearest whole number – example: 24.6 = 25. Do not spell out the number – example: write 3, not three.

If you are part of a multi-employer group health plan and you want Medicare to be primary, has CMS approved a Small Employer Exception for your group? ☐ Yes ☐ No

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.): __________

Number of employees eligible to enroll in the plan per eligibility provisions set by the Subscriber Group: __________

Number of employees enrolling: __________
A Refusal of Coverage/Waiver is included for all eligible employees not enrolling: ☐ Yes ☐ No

Number of dependents enrolling:__________
A Refusal of Coverage/Waiver is included for all eligible dependents not enrolling: ☐ Yes ☐ No

Total number of employees waiving coverage: __________

## 24-hour coverage

24-hour coverage is provided for sole proprietors, partners and corporate officers of the Subscriber Group who are not subject to mandatory workers' compensation coverage. 24-hour coverage does not extend to any family member who is not also a sole proprietor, partner or corporate officer of the Subscriber Group. The name and title of an individual eligible for 24-hour coverage must be provided at the time of group or individual enrollment.

Name: ______________________________ Title: ______________________________

Name: ______________________________ Title: ______________________________

Name: ______________________________ Title: ______________________________

## Other current coverages

Is this coverage replacing a current group medical plan? ☐ Yes ☐ No

If "Yes," please list the name and policy number of the current carrier: ______________________________

Is other group coverage(s) offered? ☐ Yes ☐ No

If "Yes," please list the carriers and coverages offered: ______________________________

If "Yes," confirm rate structure is similar amongst all carriers: ☐ Yes ☐ No

[2] This information is for rating purposes and not to determine group size. The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) and is not based on the multiple tax identification status of the related entities.

*(continued)*

## Subscriber Group statement

1. We wish to enroll as a group account with Health Net Health Plan of Oregon, Inc. (referred to herein as the Plan). It is understood that the coverage will not be in effect until the application has been accepted by the Plan.
2. We understand the eligibility rules applicable to employee enrollment and guaranteed renewability except for nonpayment and other reasons allowed by Oregon law. Failure to maintain these minimum contribution and minimum participation requirements may result in termination or nonrenewal.
3. We agree, in the event this application is accepted, to cooperate with the Plan in complying fully with the requirements of section 2715 of the Public Health Service Act to disclose summary plan and benefit information to eligible and renewing plan participants and beneficiaries. Applicant acknowledges that it has received information provided by the Plan's "Summary of Benefits and Coverage to Eligible and Covered Persons – Instructions for Reproduction and Distribution" and agrees to assume the responsibilities assigned to the "Group" thereunder.
4. We understand premiums are prepaid and are due no later than the first day of each month.
5. We understand a member's coverage terminates the last day of the month in which that member ceases to be eligible under group eligibility provisions.
6. We understand that there will be one open enrollment period per contract year. The period will be for 30 days prior to the renewal effective date.
7. We enclose the amount of $ __________ as a deposit on the first month's premium (minimum deposit of 90% of premium). Upon acceptance of the application by the Plan, we promise to pay the Plan any balance necessary to constitute full initial payment for the group benefits identified in this application.
8. Applicant's signature below confirms: a) Applicant's agreement to all the terms and conditions set out in this Application, including the Conditions of Enrollment and Underwriting Assumptions; and b) the accuracy and completeness of the information that the Applicant has entered in this Application.
9. The Agreement, consisting of the Plan Contract to be issued as the description of coverage and supplemented by this Group Application, has been entered into between Health Net Health Plan of Oregon, Inc. and the Subscriber Group in order to provide eligible enrolled employees and eligible enrolled dependents with the health care benefits as specified in the Plan Contract. The Agreement may be amended with the mutual written consent of the Subscriber Group and Health Net Health Plan of Oregon, Inc. at any time, subject to state and federal regulations.

| SUBSCRIBER GROUP | HEALTH NET HEALTH PLAN OF OREGON, INC. |
|---|---|
| Executed at: ______________________________, Oregon | Executed at: Tigard, Oregon |
| Date accepted: | Date accepted: |
| Signature of authorized Subscriber Group representative: | Signature of authorized Plan representative: |
| Print name: | Print name: |
| Title: | Title: |

*(continued)*

## Producer statement

I certify that all 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 establishment or is otherwise eligible to contract for insurance coverage in the State of Oregon.
2. All participation requirements have been explained, and the minimum participation requirements have been met.
3. Coverages, enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the applicant or employer.
4. Deductibles, copayments and coinsurance (if applicable) have been fully explained and understood by the employer.
5. I know of no reason why the Plan coverage should not be offered, and I recommend that such coverage be offered.

**Note:** If you are not currently licensed by the State of Oregon and appointed by Health Net Health Plan of Oregon, Inc., attach an executed copy of Health Net's producer agreement and your current license. Commissions will not be paid prior to licensing and formal appointment.

**Producer signature:** ______________________________ **Date:** ______________________

Producer of record (print name): ______________________________ Producer number: ______________________

Name of firm/agency: ______________________________ Email address: ______________________

Commission level: ______________________________ Telephone number: ______________________

Split commission – Secondary producer commission percentage:__________

Secondary producer (print name): ______________________________ Secondary producer number: ______________________

| FOR OFFICE USE ONLY | **AE:** | | **AM:** |
|---|---|---|---|
| | **Size:** | **Region:** | **RMC:** |

Health Net Health Plan of Oregon, Inc., 13221 SW 68th Pkwy., Ste. 200, Tigard, Oregon 97223 · 1-888-802-7001 · www.healthnetoregon.com

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## Nondiscrimination Notice

Health Net Health Plan of Oregon, Inc. (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

**HEALTH NET**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at 1-888-802-7001 (TTY: 711).

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

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**English**
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call 1-888-802-7001 (TTY: 711).

**Amharic**
ለቋንቋ አገልግሎት ምንም ክፍያ የለውም። አስተርጓሚ ማግኘት ይችላሉ። የተነበበልዎትን እና የተወሰኑ በቋንቋዎ የተላኩልዎትን ሰነዶች መግኘት ይችላሉ። ለእርዳታ፣ ለደንበኞች ግንኙነት ማዕከል በመታወቂያ ካርድዎ ላይ ያለውን ቁጥር ይደውሉ ወይም በ 1-888-802-7001 (TTY: 711) ይደዉሉ።

**Arabic**
الخدمات اللغوية المجانية. يمكنك الاستعانة بمترجم فوري، كما يمكنك طلب قراءة المستندات عليك وإرسال بعض منها إليك بلغتك. للحصول على المساعدة، يمكنك الاتصال بمركز اتصالات العملاء على الرقم الموجود على بطاقة معرف العضوية الخاصة بك أو الاتصال على 1-888-802-7001 (TTY: 711).

**Chinese**
免費語言服務。您可以取得口譯服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥打會員卡上的電話號碼聯絡客戶聯絡中心，或撥打電話 1-888-802-7001 (聽障專線 (TTY)：711)。

**Cushite (Oromo)**
Tajaajila afaaniif kaffaltii hin qabu. Turjubaana argachuu ni dandeessu. Sanadii isiniif dubbifamee fi afaan keessaniin muraasaan isniif ergame argachuu ni dandeessu. Gargaarsaaf, Wiirtuu Qunnamtii Maamilaa tiif lakkoofsicha kaardii enyummaa keessan irra jirutti bilbilaa ykn 1-888-802-7001 (TTY: 711) itti bilbilaa.

**German**
Es stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Sie können einen Dolmetscher hinzuziehen. Die Dokumente können Ihnen vorgelesen werden und einige sind in Ihrer Muttersprache erhältlich. Für Unterstützung rufen Sie bitte unser Kundendienstzentrum unter der auf Ihrer Versicherungskarte angegebenen Nummer oder unter der Rufnummer 1-888-802-7001 (TTY: 711) an.

**Japanese**
無料の言語支援サービス。通訳をご利用いただけます。日本語で文書を読み上げたり、文書によっては日本語版をお届けすることも可能です。支援をご希望の方は、IDカードに記載の番号にてカスタマーコンタクトセンターまでお電話いただくか、1-888-802-7001 (TTY: 711)までお電話ください。

**Korean**
무료 언어 서비스. 귀하는 통역사를 이용하실 수 있습니다. 귀하에게 편한 언어로 서류 낭독 서비스 및 번역 서비스를 받으실 수 있습니다. 도움이 받으시려면 본인의 ID 카드에 기재된 고객 서비스 센터 안내번호 또는 1-888-802-7001 (TTY:  711)번으로 전화해주십시오.

**Cambodian (Khmer)**
សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែបាន។ អ្នកអាចឲ្យគេអានឯកសារជូនអ្នក និងផ្ញើឯកសារខ្លះជូនអ្នក ជាភាសារបស់អ្នក។ សំរាប់ជំនួយ ទូរស័ព្ទទៅមជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន តាមលេខនៅលើប័ណ្ណ ID របស់អ្នក ឬហៅលេខ 1-888-802-7001 (TTY: 711)។

**Laotian**
ການບໍລິການດ້ານພາສາທີ່ບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍນາຍແປພາສາ. ທ່ານສາມາດອ່ານເອກະສານ ແລະ ຈຳນວນໜຶ່ງໄດ້ສົ່ງໃຫ້ທ່ານເປັນພາສາຂອງທ່ານແລ້ວ. ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, ໂທຫາສູນຕິດຕໍ່ລູກຄ້າໄດ້ທີ່ເລກໝາຍຢູ່ເທິງບັດ ID ຂອງທ່ານ ຫຼື ໂທ 1-888-802-7001 (TTY: 711).

**Punjabi**
ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਲਈ ਕੋਈ ਲਾਗਤ ਨਹੀਂ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਤੁਹਾਨੂੰ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਦਸਤਾਵੇਜ਼ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ID ਕਾਰਡ 'ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ 1-888-802-7001 (TTY: 711)।

**Russian**
Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика.
Вам могут прочесть документы на русском языке и выслать переводы некоторых из них. Если вам требуется помощь, звоните в Центр обслуживания клиентов по номеру, указанному на вашей идентификационной карте, или по номеру 1-888-802-7001 (линия TTY: 711).

**Spanish**
Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llame al Centro de Comunicación con el Cliente al número que se encuentra en su tarjeta de identificación o llame al 1-888-802-7001 (TTY: 711).

**Tagalog**
Mga Walang Bayad na Serbisyo sa Wika. Maaari kayong kumuha ng tagasaling-wika (interpreter). Maaaring basahin sa inyo ang mga dokumento at ipadala sa inyo ang ilan nang nakasalin sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numero sa inyong ID card o tumawag sa 1-888-802-7001 (TTY: 711).

**Ukrainian**
Безкоштовні послуги перекладу. Ви можете скористатися послугами перекладача.
Вам можуть прочитати документи на українській мові та надіслати переклади деяких із них. Якщо вам потрібна допомога, телефонуйте у Центр обслуговування клієнтів за номером, вказаним на вашій ідентифікаційній карті, або за номером 1-888-802-7001 (лінія TTY: 711).

**Vietnamese**
Dịch vụ ngôn ngữ miễn phí. Quý vị có thể yêu cầu phiên dịch viên. Quý vị có thể yêu cầu đọc các tài liệu và gửi một số tài liệu cho quý vị bằng ngôn ngữ của quý vị. Để được trợ giúp, hãy gọi đến Trung tâm Liên lạc Hội viên theo số điện thoại trên thẻ nhận dạng của quý vị hoặc gọi đến số 1-888-802-7001 (TTY: 711).

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