



Large Group  
**Application**  
**(51+ EMPLOYEES)**

**Application must be typed or completed in blue or black ink.**

<b>Subscriber Group information</b>		
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:
<b>Type of organization</b>		
<input type="checkbox"/> Corporation	<input type="checkbox"/> Association (as defined by ORS 743.522)*	Nature of business:
<input type="checkbox"/> Sole proprietorship	<input type="checkbox"/> Trust (as defined by ORS 743.522)*	Date of business inception:
<input type="checkbox"/> Partnership	<input type="checkbox"/> Discretionary group (as defined by ORS 743.522)*	SIC code:
<input type="checkbox"/> Other (describe): _____		
<p><b>*Is the association/trust/discretionary group filed and approved with the Division of Financial Regulation as a group policyholder?</b></p> <p><input type="checkbox"/> Yes, current Division of Financial Regulation Approval #: _____</p> <p><input type="checkbox"/> No    <input type="checkbox"/> N/A</p>		

(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

(Note: Federal, state and local governments, as well as church plans, are not subject to ERISA requirements.)

## 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, domestic partner, and child(ren), from birth to age 26, of legal spouse or domestic partner.

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

<input type="checkbox"/> PPO: _____ _____	<input type="checkbox"/> Prescription: _____ <input type="checkbox"/> Dental: _____ <input type="checkbox"/> Vision: _____ <input type="checkbox"/> Alternative Care buy-up: _____
HSA Integration (only available with High Deductible plans) <input type="checkbox"/> Yes <input type="checkbox"/> No HRA Integration (only available with PPO plans) <input type="checkbox"/> Yes <input type="checkbox"/> No Select one of the following for HRA: <input type="checkbox"/> HRA Pays First <input type="checkbox"/> Member Pays First <input type="checkbox"/> HRA with Debit Card	
<input type="checkbox"/> CommunityCare 1T: _____	
<input type="checkbox"/> CommunityCare 3T: _____	
<input type="checkbox"/> Other riders: _____ _____	

**Monthly rates. Please attach a copy of the sold rates.**

Indicate the group's plan selection by highlighting all plans and the corresponding plan riders.

**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

**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 Declination 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.

(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+. Count all employees throughout the U.S. regardless of if they are eligible for coverage, including full-time, part-time, leased, etc. Do not include 1099 employees or seasonal workers.

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.<sup>1</sup>

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: \_\_\_\_\_

Number of dependents enrolling: \_\_\_\_\_

Total number of employees waiving coverage: \_\_\_\_\_

A Waiver/Declination of Coverage is included for all eligible employees and dependents not enrolling:  Yes  No

## 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

<sup>1</sup>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 the Plan's "Summary of Benefits and Coverage to Eligible and Covered Persons – Instructions for Reproduction and Distribution" will be issued within 7 business days of receipt of the Large Business Group Application 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: \_\_\_\_\_