GROUP CONTRACT APPLICATION

FOR SMALL GROUPS IN OREGON

Samaritan Health Plans

Submission deadline: Your application must be received and complete with no missing or incorrect information by the 20th of the month prior to your effective date. If your application is not complete or received by the 20th, coverage for your group may be delayed. Submission of this Group Contract Application does not guarantee group coverage. Samaritan must review all applications to ensure that they meet company underwriting guidelines and state requirements. You should not assume coverage is in place until we notify you that your application has been approved.

EMPLOYER INFORMATION

Date:	Requested effective date:	
Company name:		Total number of benefit eligible employees as defined by the state of Oregon:
Type of business:	Original business start date (mm/dd/yyyy):	
Previous Samaritan Health Plans group? ❑ Yes ❑ No	If yes, previous SHP group number:	
Primary contact name:	Title:	
Phone:	Fax:	Email address:
Street address:	City: , Oregon	Zip:
Secondary contact name:	Title:	
Phone:	Fax:	Email address:
Street address:	City: , Oregon	Zip:

BILLING INFORMATION (if different from above)

Primary contact name:	Title:	
Phone:	Fax:	Email Address:
Mailing address:	City: , Oregon	Zip:

BUSINESS INFORMATION

Business structure: (check all that apply)

❑ Corporation	❑ S-Corporation	❑ Partnership	❑ Not for profit
❑ Association	❑ State government	❑ Local government	❑ Church group
❑ Publicly traded corporation	❑ Privately held corporation	❑ Sole proprietor	❑ Other _____

Company headquartered in (state):	In business since:	Tax ID number:
Choose one: ❑ Branch ❑ Subsidiary	SIC code:	
Type of business (please be specific):	ERISA PLAN YEAR:	

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OTHER AFFILIATES

Business structure: (check all that apply)

❑ Corporation	❑ S-Corporation	❑ Partnership	❑ Not for profit
❑ Privately held corporation	❑ Sole proprietor	❑ Local government	❑ Church group
❑ Other _____	Choose one: ❑ Branch ❑ Subsidiary		SIC code:

Company headquartered in (state):	In business since:	Tax ID number:

Type of business (please be specific):

PLAN SPONSOR (Choose one)

❑ Employer	❑ Labor organization	❑ Trustees of a fund established by one or more employers or labor organizations

PLAN ADMINISTRATOR (If different from above)

Name:	Contact:
Phone:	

ELIGIBILITY & CONTRIBUTION

HOURS Minimum hours required per week (17.5 or more):	**ENROLLMENT** Number of employees expected to enroll:
❑ Employee-only coverage	❑ Employee + Dependent(s)/Domestic Partner coverage

MEDICARE Total Number of employees enrolled for Medicare coverage:

CONTRIBUTION Employer must contribute at least 50% of the employee only rate of the lowest premium plan chosen. Please indicate percentage or dollar amount of monthly premium employer contribution for:

Employees _____% or $_____ Dependents: _____% or $_____

Service Area(s) of employer:

CONTINUATION

Consult your legal counsel if you have questions about how to accurately determine your employee count for the purposes of COBRA and TEFRA/DEFRA. Follow Department of Labor rules to accurately count part-time employees.

Is your group subject to **COBRA**? ❑ Yes ❑ No

Is your group subject to **TEFRA/DEFRA**? ❑ Yes ❑ No

Is your group subject to the **ERISA** claim regulations issued by the Department of Labor? ❑ Yes ❑ No

MEDICARE SECONDARY PAYER

Is your group subject to **Medicare Secondary Payer**? ❑ Yes ❑ No

If your group is subject to Medicare Secondary Payer provision, do you have 20 or more employees for each working day in each 20 or more calendar weeks in the current calendar year or the preceding calendar year? ❑ Yes ❑ No

You must count all employees on the employment payroll. Do not count retirees, COBRA qualified beneficiaries, individuals on other continuation option or self-employed individuals

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NEW HIRE ELIGIBILITY

❑ Date of first hire *or* First of the month following: ❑ Date of hire ❑ 30 days ❑ 60 days

Waive probationary period at initial enrollment? ❑ Yes ❑ No | Eligibility remarks:

COVERAGE HISTORY

Previous Carrier: | Previous Group Number:

Remarks:

COVERAGE OPTIONS*

❑ Samaritan Oregon Standard Bronze HSA	❑ Samaritan Oregon Standard Silver	❑ Health and Wellbeing 5000
❑ Health and Wellbeing 2500	❑ New Performance PPO	❑ Health and Wellbeing 3000

❑ Samaritan Vision (only available for non-standard plan options)

*These plans do not include pediatric dental coverage, which is a required component of coverage under health care reform. Please speak with your agent or broker about obtaining this coverage separately.

HEALTH SAVINGS ACCOUNT (HSA)

Will HSA eligible plan be chosen? ❑ Yes ❑ No | HSA Vendor:

Amount of HSA (member annual contribution):

BROKER INFORMATION (To be completed by broker/agency)

Broker:	Firm:	Tax ID No./ SSN:
Phone:	Fax:	
Email address:		
Mailing address:		
City:	State:	Zip:

BROKER STATEMENT

I certify that all the information contained in this application is correct to the best of my knowledge. I also certify that:

1. This firm meets the definition of an Oregon Small Employer and/or small employer and complies with Samaritan Health Plans underwriting requirements for small employers.
2. Coverage(s), enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the employer.

Print name: | Title:

Signature: | Date:

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EMPLOYER STATEMENT

1. We wish to apply to enroll our firm as a group with Samaritan Health Plans. We understand payment of premium will be deemed to be assent to all terms of the group contract, including modifications and renewals that are sent to us.
2. We understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted.
3. We understand the obligation to provide the Summary of Benefits and Coverage (SBC) to eligible employees at open enrollment and when newly eligible or newly hired, as required by the Patient Protection and Affordable Care Act and related regulations and rules, and accept responsibility for delivering the document.
4. We affirm that we will obtain pediatric dental coverage, as required by federal law, and that we will notify Samaritan Health Plans if we do not obtain coverage.
5. The broker/producer stated above is our Producer of record for Samaritan Health Plans and will remain such until this application is rescinded in writing.
6. To the best of our knowledge and belief, the foregoing statements are true and complete and, along with the group application, shall be the basis for the issuance of coverage under the group policy and shall become part thereof.
7. We understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company; and such intent to defraud may be subject to criminal and civil penalties and Samaritan Health Plans may cancel the group account and refuse to pay claims.
8. We understand that Samaritan Health Plans may update and/or modify this agreement at any time on 30 days notice.
9. We understand that Samaritan Health Plans will provide us with a copy of the Summary of Benefits and Coverage (SBC) electronically.

Print name:	Title:
Signature:	Date:

FOR SAMARITAN USE ONLY

Tier	Medical premium	Pharmacy premium	Premium total
EE			
ES			
EC			
EF			

Tier Key: **EE** - Employee **ES** - Employee & Spouse **EC** - Employee & Children **EF** - Employee & Family

Account executive:	Account specialist:

Check amount:	Check number:	Premium:

Group number:	Effective date:	Subscribers:	Members:

BROKER NOTE

1. Please provide previous coverage billing.
2. Please provide previous insurance certificate.
3. Please provide copy of sold Quote.

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