Providence Health Plan

BCOCSales@Providence.org
ProvidenceHealthPlan.com

Bend Chamber of Commerce Association

Master Group Application — 2024 Contract Year

For new group enrollment, please submit the following items no later than the 10th of the month prior to your effective date, or there may be delays to the processing and activation of your group:

- ☐ Completed and signed master group application
- ☐ Completed employee enrollment/waiver forms or spreadsheet for ALL employees *(forms must be signed)*

Materials should be submitted to Johnson Benefit Planning by email: jbpadmin@JohnsonBenefitPlanning.com

Section A: Group Information

COMPANY'S LEGAL NAME (INCLUDE PUNCTUATION AND ABBREVIATIONS) _____ NAME OF LOCAL CHAMBER _____

DOING BUSINESS AS (DBA) _____ REQUESTED EFFECTIVE DATE _____

COMPANY HEADQUARTERS' PHYSICAL ADDRESS _____ CITY, STATE, ZIP _____

COUNTY _____ PHONE NUMBER _____ FAX NUMBER _____

Group Benefits Administrator/Primary Contact

NAME _____ TITLE _____

MAILING ADDRESS _____ CITY, STATE, ZIP _____

PHONE NUMBER _____ FAX NUMBER _____ EMAIL ADDRESS _____

Billing Contact (if different from above)

NAME _____ TITLE _____

BILLING ADDRESS _____ CITY, STATE, ZIP _____

PHONE NUMBER _____ FAX NUMBER _____ EMAIL ADDRESS _____

Business Information

Type of business

- ☐ Auto and Motorsports
- ☐ Business and Professional
- ☐ Communications and Utilities
- ☐ Contractors
- ☐ Healthcare Services
- ☐ Human Services
- ☐ Manufacturing
- ☐ Real Estate
- ☐ Wood Products

Add **BHS COBRA Administration Services**? ☐ Yes ☐ No

If yes, please attach **BHS intake packet**

TAX IDENTIFICATION NUMBER

Your first month premium will be billed via an invoice. Your group's primary and billing contacts will be registered to access our Employer Group Portal. Access to the portal will become available on the group effective date and will allow you to pay your bill online one time or set up recurring payments, as well as manage eligibility and enrollment.

Section B: Benefits and Rates – Please attach rates page to this application

Medical Plan 1	
Premier Plans:	-
Core Plans:	-
HSA-E Plans:	-
Base Plans:	-
Medical Plan 2	
Premier Plans:	-
Core Plans:	-
HSA-E Plans:	-
Base Plans:	-
Medical Plan 3	
Premier Plans:	-
Core Plans:	-
HSA-E Plans:	-
Base Plans:	-

Vision $400 Plan: ☐ YES ☐ NO

CDHP Accounts – The following optional integrated accounts are serviced by HealthyEquity:

Health Savings Account (HSA)
Can be paired with any HSA Qualified plan

☐ Yes ☐ No

Flexible Spending Account (FSA)
Can be paired with any non-HSA plan

☐ Yes ☐ No

Health Reimbursement Account (HRA)
Can be paired with any non-HSA plan

☐ Yes ☐ No

Limited Purpose Flexible Spending Account (LPFSA)
Can be paired with a HSA for dental and vision care

☐ Yes ☐ No

If you opt for any of the above services with HealthEquity, please complete this New Business form online.

Section C: Employee Eligibility

How many hours per week must employees work to be eligible for health care coverage? _____ HOURS PER WEEK

(Employer may determine hours worked for eligibility between 17.5 and 40 hours per week — please note a large employer is advised not to exceed 30 hours)

Eligibility waiting period

☐ Date of hire, or First of the month following: ☐ 30 days ☐ 60 days ☐ Date of hire
☐ 90 Calendar days; Effective on 91st calendar day

Waive probationary period at initial enrollment? ☐ Yes ☐ No

If the last day of the probationary period falls on first day of the month, when will the new employee be effective?

☐ Eligible that day
☐ Must wait until the first day of the following month or 91st day, whichever comes first

This plan will cover opposite gender/unregistered domestic partners?: ☐ Yes ☐ No

Status Change

If an employee changes from part-time to full-time or from temporary to permanent, how will you apply probation?

☐ Credit time as part-time or temporary toward probationary wait period (not allowed for new hires transferring from a temp agency)
☐ Probationary wait period begins when status changes (default)

Section D: Previous or Other Carrier Information — Medical

Does the group currently have medical benefits? ☐ Yes ☐ No *If yes, please provide carrier information below.*

_____ CURRENT CARRIER _____ TERM DATE _____ GROUP/POLICY NUMBER

Section E: Employer Contribution

The minimum employer contribution amount is 50% of the employee premium for the lowest cost plan.
Please state your contribution toward: _____% EMPLOYEE _____% DEPENDENT

Section F: Employees Being Insured

1. ____ Total number of employees (full-time, part-time, owner, partner, principal, probationary, waiver; exclude continuation)
2. ____ Total number former employees currently on Continuation (submit Application)
3. ____ Total number of employees who do not qualify due to hourly requirement
4. ____ Total number of employees who do not qualify due to waiting period requirement
5. ____ Total number of employees waiving coverage due to other qualified coverage (Spousal group coverage, other employment group coverage, Medicare, Tricare/VA, Medicaid (OHP), or Indian Health Service)
6. ____ Total number of employees waiving coverage due to non-qualified reasons (no coverage, individual coverage)

A. ____ TOTAL NUMBER OF EMPLOYEES: Add numbers 1 and 2 above
B. ____ TOTAL NUMBER OF EMPLOYEES NOT ENROLLING: Add numbers 3 through 6 above
C. ____ TOTAL NUMBER OF EMPLOYEES ENROLLING, including continuation: Subtract B from A above

Section G: Producer of Record Information

AGENCY

AGENCY ADDRESS

PRODUCER NAME

Section H: Producer 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 organization complies with Providence Health Plan underwriting requirements for the Bend Chamber of Commerce Association Health Plan.
2. All participation requirements have been met.
3. Coverage(s), enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the employer.

PRINT NAME

PRINT TITLE

PRODUCER SIGNATURE

DATE

Section I: Employer Statement

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

1. We wish to apply to enroll our organization as a group with Providence Health Plan. 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. Minimum participation requirements for specific coverage(s) have been fully explained in detail, and we understand that they must be met and maintained in order for the group to remain eligible for coverage.
4. The broker/producer stated above is our Producer of record for Providence Health Plan and will remain such until this application is rescinded in writing.
5. To the best of our knowledge and belief, the foregoing statements are true and complete.
6. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

PRINT NAME

PRINT TITLE

AUTHORIZED GROUP SIGNATURE

DATE

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