

Date \_\_\_\_\_  
Group name \_\_\_\_\_  
Type of business \_\_\_\_\_ Original business start date (mm/dd/yy) \_\_\_\_\_  
Requested effective date \_\_\_\_\_  
Previous Providence Health Plan group Yes No If yes, previous PHP group # \_\_\_\_\_

Contract contact \_\_\_\_\_ Billing contact \_\_\_\_\_  
Contract contact mailing address \_\_\_\_\_ Billing/mailling address \_\_\_\_\_  
City \_\_\_\_\_ State, ZIP \_\_\_\_\_ City \_\_\_\_\_ State, ZIP \_\_\_\_\_  
Phone# \_\_\_\_\_ Fax# \_\_\_\_\_ Business Fed Tax ID # (required) \_\_\_\_\_  
Email address \_\_\_\_\_ Business license # \_\_\_\_\_  
Physical address \_\_\_\_\_ \*CMS group size # \_\_\_\_\_  
City \_\_\_\_\_ State, ZIP \_\_\_\_\_ \*CMS group size definition: The Centers for Medicare & Medicaid Services determine group size as the current total number of nationwide full-time employees, part-time employees, seasonal employees and partners. Do not count retirees, COBRA-qualified beneficiaries, individuals on other continuation options, or self-employed individuals who participate in the employer's group health plan.

**Eligibility/contribution**

Subject to COBRA or state continuation Dependents or students eligible to age 26.  
Employer will contribute: \$ \_\_\_\_\_ or \_\_\_\_\_ % toward employee premium, and \$ \_\_\_\_\_ or \_\_\_\_\_ % toward dependent premium.  
**Employer must contribute a minimum of 50% toward the employee premium**

Minimum hours required per week (17.5 or more) \_\_\_\_\_ Employee-only contract

**New hire eligibility:**

Date of hire \_\_\_\_\_ Waive probationary period at initial enrollment? Yes No

**OR**  
First of the month following: 30 days 60 days 90 days Date of hire

Eligibility/contribution remarks: \_\_\_\_\_

Previous carrier \_\_\_\_\_ Previous group # \_\_\_\_\_  
Remarks: \_\_\_\_\_

Providence Health Plan  
Portland office: P.O. Box 4327  
Portland, OR 97208-4327  
Phone: 503-574-6665 or 877-245-4077  
Fax: 503-574-7543  
Eugene office: 1500 Valley River Drive, Suite 200  
Eugene, OR 97401  
Phone: 541-242-9012 or 877-245-4077  
Fax: 800-889-8218

# Oregon small group plan options

Core Essentials
25/30/50/5000 7500 cd
25/30/50/5000 5000 cd
25/30/50/5000 3000 cd
25/30/50/5000 2000 cd
25/30/50/5000 1500 cd
25/30/50/5000 1000 cd
Core Advantages
25/30/50/5000 7500 cd
25/30/50/5000 5000 cd
25/30/50/5000 3000 cd
25/30/50/5000 2000 cd
25/30/50/5000 1500 cd
25/30/50/5000 1000 cd
Core Alternatives
25/30/50/5000 7500 cd
25/30/50/5000 5000 cd
25/30/50/5000 3000 cd
25/30/50/5000 2000 cd
25/30/50/5000 1500 cd
25/30/50/5000 1000 cd

Open Option (OP)
20/20/40/4000 5000 cd
25/20/40/3000 3000 cd
20/20/30/3000 2000 cd
15/30/50/2500 1500 cd
25/20/30/2500 1500 cd
15/30/50/2500 1000 cd
25/20/30/2500 1000 cd
15/20/30/2000 1000 cd
20/20/40/2500 750 cd
25/20/40/3000 500 cd
15/20/40/2000 500 cd
15/20/40/2000 250 cd
10/10/20/1700 250 cd

Personal Option (PE)
25/30/3000 2000 Ded
15/30/3000 2000 Ded
25/30/2500 1500 Ded
15/30/2500 1000 Ded
20/20/2500 750 Ded
25/20/3000 500 Ded
20/20/2000 500 Ded
15/20/2000 500 Ded
10/20/1700 250 Ded
10/20/1200

HSA-Qualified
20/40/5500 1500 cd
20/40/5500 2500 cd
20/40/5500 3500 cd
50/50/5500 1500 cd
0/0/5500 cod

Basic Plan with Rx
15/50/300 w/Rx \$15/50%

Dual Option - Basic
Combine any two plans within this category
CORE ES 25/30/50/5000 5000 cd
CORE AL 25/30/50/5000 7500 cd
CORE AD 25/30/50/5000 7500 cd
CORE AL 25/30/50/5000 5000 cd
CORE AD 25/30/50/5000 5000 cd

Dual Option - Expanded
Combine any two plans within this category
HSA 0/0/5500 cod
CORE AD 25/30/50/5000 2000 cd
CORE AL 25/30/50/5000 2000 cd
PE 25/30/3000 2000 ded
CORE AD 25/30/50/5000 1500 cd
CORE AL 25/30/50/5000 1500 cd
OP 25/20/40/3000 3000 cd
PE 25/30/2500 1500 ded
CORE AD 25/30/50/5000 1000 cd
CORE AL 25/30/50/5000 1000 cd

Dual Option - Premium
Combine any two plans within this category
HSA 20/40/5500 2500 cd
OP 25/20/30/2500 1500 cd
PE 20/20/2500 750 ded
PE 25/20/3000 500 ded
OP 25/20/30/2500 1000 cd
PE 15/20/2000 500 ded
OP 15/20/30/2000 1000 cd
OP 20/20/40/2500 750 cd
OP 25/20/40/3000 500 cd
OP 15/20/40/2000 500 cd

Rx
15/50%
15/45 500 ded
15/75
15/45 250 ded
15/60
15/45
5/10/50/50%/2000
15/30
10/30
20/40
10/50/1000
5/15/40/50\$ 2000
10/20

Rextra
15/45 500 ded
15/45 250 ded
15/45
15/30

Riders
<b>Vision</b>
200
300
<b>Chiropractic</b>
10/1500
<b>Alternative Care</b>
10/1500
15/500 any licensed provider
15/1000 any licensed provider

**CDHP Accounts (HSA / HRA / FSA) The following integrated accounts are serviced by HealthEquity (HE)**

HSA (Health Savings Account) To be combined with HSA qualified plan.

HRA (Health Reimbursement Account) To be combined with non-HSA qualified plan. A separate HRA / FSA employer application must be sent to HE.

FSA / LFSA (Flexible Spending Account) To be combined with any plan. A separate HRA / FSA employer application must be sent to HE.

FOR PROVIDENCE USE ONLY				RATES		FOR PROVIDENCE USE ONLY		
Tier	Medical	In Net	Out Net	Rx	Vision	Chiro	Alternative	TOTAL
S								
SS								
SSC								
SC								

Tier key: S = Subscriber, SS = Subscriber & Spouse, SSC = Subscriber & Spouse & Child(ren), SC = Subscriber & Child(ren)

FOR PROVIDENCE USE ONLY		RATES	
Tier	CDHP – HSA	CDHP – HRA	TOTAL
S			

Tier key: S = Subscriber

Small-group representative \_\_\_\_\_ Account specialist \_\_\_\_\_

Check amount \$ \_\_\_\_\_ Check # \_\_\_\_\_ Premium \_\_\_\_\_

Group # \_\_\_\_\_ Onyx # \_\_\_\_\_ Elig # \_\_\_\_\_ Subs \_\_\_\_\_ Mbrs \_\_\_\_\_

## PRODUCER INFORMATION

Producer \_\_\_\_\_ Commission schedule = PMPM  
Firm \_\_\_\_\_ Phone \_\_\_\_\_ Tax ID#/SSN \_\_\_\_\_  
Full address \_\_\_\_\_  
Original contract mailed to    Group    Producer    Copy mailed to    Group    Producer

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## 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 firm is a bona fide business meeting the definition of Oregon Small Employer and/or a small employer as defined by HIPAA and complies with Providence Health Plan underwriting requirements for small employers.
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.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Print name and title

\_\_\_\_\_  
Producer signature

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## EMPLOYER STATEMENT

1. We wish to apply to enroll our firm 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. We understand that coverage is provided on a sole carrier basis only.
4. 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.
5. 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.
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 Providence Health Plan may cancel the group account and refuse to pay claims.
8. We understand that 30 days' notice is required to change this agreement.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Print name and title

\_\_\_\_\_  
Authorized group signature

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Portland office: P.O. Box 4327  
Portland, OR 97208-4327  
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Fax: 503-574-7543

### Providence Health Plan

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