Master Group Application

Samaritan Health Plans

For Large Groups in Oregon

Application 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 Policy Application does not guarantee group coverage.

Contract: This Application, once executed and approved, and the Master Large Group Policy provided with the Application, together form the Contract between the Applicant and Samaritan Health Plans.

Submit: Fax to Attn: Sales Department at 541-768-4294 or email to broker@samhealth.org. Please complete form in black ink.

Applicant Information

Date:	Requested effective date:
Legal Business 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:	Title:
Address:	City: , Oregon ZIP
Phone: Fax:	Email:

Billing Information *(if different from above)*

Primary contact:	Title:
Address:	City: , Oregon ZIP
Phone: Fax:	Email:

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):	Plan year:

Eligibility and Contribution

HOURS Minimum hours required per week: ______________________ Number of benefit eligible employees : ___________________

❑ Employee-only contract*

** By checking this box dependents are ineligible to enroll during the 12-month contract.*

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 $____________

RETIREE Is group coverage available to retiree? ❑ Yes ❑ No Is the group a local government (school, city, county?) ❑ Yes ❑ No
Approval dependent on Samaritan Policy and Approval. If you offer health or dental coverage to your retirees, please attach the requirements and employer premium contribution (if any).

Continuation

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

Is your group subject to Federal COBRA? ❑ Yes ❑ No | Is your group subject to ERISA? ❑ Yes ❑ No

Medicare Secondary Payer

Total number of employees nationwide: ______________________

*For Medicare Secondary Payer purposes. Medicare Secondary Payer – A term used when Medicare is not responsible to pay first on healthcare claim. 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.

New Hire Eligibility

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

❑ First of the month following the date of hire. If hired on the first of the month, coverage is effective that day.

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

Coverage History

Previous carrier: | Previous group number:

Remarks:

Coverage Options

Plan option____________________ HDHP_______________________ ER Copay______________________ OOP Max_____________________

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Plan option____________________ HDHP_______________________ ER Copay______________________ OOP Max_____________________

Additional Coverage

❑ Massage Therapy Rider ($25/$2500) ❑ Samaritan Vision Plan ❑ EAP ________________

Broker Information *(to be completed by broker/agency)*

Broker:	Firm:	Tax ID/SSN:
Phone:	Fax:	Email:

Mailing address:

City:	State:	ZIP:

Broker Statement

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

1. This Applicant meets the definition of an Oregon Large Employer and complies with Samaritan Health Plans underwriting requirements for large group employers.
2. Coverage(s), enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the Applicant.
3. I, the undersigned producer for this group, affirm that the information provided on this application is complete and correct to the best of my knowledge.

Print name:	Title:
Signature:	Date:

Employer Statement

1. This is an application for group insurance. Under no circumstances will coverage be in force until the policy is issued by Samaritan Health Plans and accepted by the employer. Once a policy is issued, the policy terms control in all cases.
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. We understand that Samaritan Health Plans will supply us with a copy of the Summary of Benefits and Coverage (SBC) electronically.

4. To the best of our knowledge and belief, the foregoing statements are true and complete and, along with this Application and the Master Group Policy, shall be the basis for the issuance of coverage under the group policy and shall become part thereof.
5. 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.
6. We understand that Samaritan Health Plans reserves the right to change the premium rates under this Contract at any time. Written notice of premium rate change, or renewal notice, will be given to the group at least 30 days prior to the effective date of the change.

Print name:	Title:
Signature:	Date: