Large Group Renewal Change Form

P.O. Box 1310, Corvallis, OR 97330 · 800-832-4580 · FAX 541-768-4294 · broker@samhealth.org · samhealthplans.org

Submit this form to Samaritan Health Plans, Sales Dept. by the 20th of the month prior to your renewal date. Visit samhealthplans.org for benefit information.

Group name:	**Group number:**	**Renewal effective date:**

Eligibility and Contribution

HOURS Minimum hours required per week: _____ | Number of benefit eligible employees: _____

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.

❑ **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).

New Hire Eligibility

Orientation Period: ❑ No ❑ Yes _____ days

Coverage is effective for new hires: ❑ First of the month following: ❑ 30 days ❑ 60 days ❑ Date of hire
❑ First of the month following the date of hire. If hired on the first of the month, coverage is effective that day.

Please note: Employer must contribute at least 50% of the employee rate of the lowest cost plan.

Coverage Options

Plan option_____ HDHP_____ ER Copay_____ OOP Max_____

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Plan option_____ HDHP_____ ER Copay_____ OOP Max_____

Plan option _____: ❑ Add ❑ Remove ❑ Continue	Plan option _____: ❑ Add ❑ Remove ❑ Continue
Plan option _____: ❑ Add ❑ Remove ❑ Continue	Plan option _____: ❑ Add ❑ Remove ❑ Continue

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

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Group Contact Information

*Provide any changes below.

Billing contact:		
Billing address:		
City:	State:	Zip:
Phone:	Email:	
Primary contact:		
Mailing address:		
City:	State:	Zip:
Phone:	Email:	

_____	_____
Print name	Print title
_____	_____
Authorized group signature	Date