Century Benefits

Please fax this completed form to 503-922-2348

Company Information

Company Name_____Contact_____

Address_____State_____Zip Code_____

Phone_____ Fax_____ Type of Industry _____

County_____ Effective Date _____ Waiting Period (0-90 days) _____

Current Carrier_____ Premium_____ Deductible_____ Copay_____

Please list all eligible employees (those working a minimum of 17.5 hours per week)

	Employee Last Name	Sex	Tobacco Y/N	DOB mm/dd/yy	Dependents		Weekly Hours	Enrollment Code	Waiving Code	Zip Code
					Spouse	# of kids				
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										

If more than 14 employees please use additional forms

Enrollment Codes	
E	Employee Only
S	Employee and Spouse
F	Family
C	Employee

Waiving Codes	
F	Contracted Employee
I	Other Ind. Coverage
V	Veteran Coverage
H	Hours Insufficient
W	Waived Coverage
S	Dependent of Employee
G	Other Group Insurance
M	Medicare

Department of Consumer & Business Services
Insurance Division

Oregon Standardized Group Profile Form

This form must be completed for both new group quotes and at plan renewal.

This form must be used for all groups applying for group health insurance to determine whether the group qualifies as a small employer.

Company:

Address:

Company headquarters:

Contact name:

Producer name:

Comments:

Average number of employees during preceding calendar year*	Number of eligible employees as of the date coverage is to take effect**	Do you intend to cover all employees?	If no, do you intend to cover one or more classes?***	Do more than 50 percent of employees work in Oregon?
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*If the total number of employees is 51 or greater, the group ***may*** qualify as a large group. If the average total number of employees is 50 or less during the preceding calendar year and you have at least two eligible employees as of the date coverage is to take effect, you are a small employer.

**The number of employees who work a regular schedule of 17.5 hours or more per week on the date coverage is to take effect. Eligible employees do not include employees who work on a temporary, seasonal, or substitute basis.

***Classes must be based on bona fide employment-based classifications consistent with your usual business practice. Employers with 25 or fewer eligible employees must cover all eligible employees.

If you are requesting coverage as a single group because you are an affiliated group of employers for the purpose of pension plans under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, the carrier must treat the affiliated group as a single group and the affiliated group must fill out one group profile form. If you are an affiliated group of employers but are not requesting coverage as a single group, each employer group in the affiliated group must fill out a separate group profile form.

Disclosure Notice for Employers

If an employer has more than 50 employees, the carrier may provide the employer a health insurance quote as a large group and must provide the quote upon request by the employer. However, the carrier must treat the employer as a small employer and must provide a quote on that basis if both of the following conditions apply:

(1) The employer's workforce consists of at least two but not more than 50 eligible employees; and

(2) Coverage is limited to eligible employees.

If an employer has no more than 25 eligible employees, the carrier must offer coverage to all eligible employees.

If an employer has 26 to 50 eligible employees, the carrier may limit coverage to the categories of employees established by the employer, but the categories must be based on bona fide employment-based classifications that are consistent with the employer's usual practice.

Health insurance carriers are required to provide a small employer quote to Oregon small employers upon request and must provide small employer coverage if an employer accepts that quote.

I am requesting a small employer quote for my group health plan _____ (Initials)

To the best of my knowledge, I certify that all the information contained herein is correct. I understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted and that additional information may be required to verify eligibility of the group.

Signature:	**Title:**	**Date:**