Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Return to:
Fax: 1 (844) 652-8276
Email: FAXORAnnualCertifications@regence.com

Group Name	
Group ID	Renewal Date

Annual Certification - Oregon
(for use with RENEWAL groups only)

In order to renew your group's coverage options with Regence BlueCross BlueShield of Oregon, it is necessary for us to ask you for information so that we can satisfy state and federal insurance regulations applicable to group health plans. **Please complete and return this form within 14 days via EMAIL: FAXORAnnualCertifications@regence.com or FAX: 1 (844) 652-8276.** We are unable to renew your group's healthcare insurance coverage without this information. If you have questions, please contact your Regence sales team or insurance producer.

1. Where is your company headquarters? City_____ State _____

2. Does the employer contribute at least 50% toward the employee premium on the lowest cost medical plan offered? ☐ No ☐ Yes

3. Does the employer contribute at least 50% toward the employee premium on the dental plan? ☐ No ☐ Yes ☐ Not applicable

4. In addition to Regence BlueCross BlueShield of Oregon, do you offer other group health benefits to your employees?
   ☐ No ☐ Yes
   If Yes, indicate the carrier's name and type of coverage _____

5. Does the employer require employees to work at least 17.5 hours per week to be eligible for health plan benefits? ☐ No ☐ Yes

6. Currently enrolled **employees** (on your monthly billing statement) _____

7. Of those employees **not enrolled** under your group coverage, please provide the number of employees included within each of the following categories. Eligibility hours are determined by the group. *Please count each employee only once.*

No coverage & meets eligibility hours		Other group coverage		Tri Care	
Individual/non-group coverage & meets eligibility hours		Christian Scientist		Probationary period	
Medicare/Medicaid/OHP		Indian Health Service		Insufficient hours	

Companies with a common owner or that are otherwise related under rules of section 414 of the Internal Revenue Code are generally combined and treated as a single employer for determining employer group size.

8. Is your company a member of a controlled group and/or affiliated with any other company? ☐ No ☐ Yes If Yes, who is the employer for purposes of filing taxes?

   _____

Average number of employees during preceding calendar year: Enter the average number of employees that were employed by your company during the **preceding** completed calendar year. This count should include: full-time, part-time, seasonal and union employees that work inside or outside the state of Oregon and employees worldwide from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees. Contracted 1099 individuals are not included.

9. Average number of employees _____ This number represents January - December of _____(YYYY)

For determining workforce size, in accordance with ORS 743B.005, "small employer" means an employer who employed an average of at least one but not more than 50 full-time equivalent (FTE) employees on business days during the preceding calendar year and who employs at least one FTE employee on the first day of the plan year. The employer must measure its workforce by counting all its common law employees. However, an employer is not considered to have more than 50 full-time employees (including FTE employees) if **both** of the following apply: (1) the employer's workforce exceeds 50 full-time employees (including FTE employees) for 120 days or fewer during the calendar year, and (2) the employees in excess of 50 employed during such 120-day period are seasonal workers. ***If your company is a member of a controlled group and/or affiliated with another company, count the employees of all members of the controlled group and/or affiliated companies.*** If the employer was not in existence throughout the preceding calendar year, the employer size is based on the average number of employees that they expect to employ in the current calendar year.

*The following **should not** be included in the counts for questions #10 through #12:*

- Leased employees
- Contracted employees
- Retired or former employees on continuation of coverage
- A sole proprietor
- A partner in a partnership
- A 2-percent S corporation shareholder
- The spouse of a person who is a sole proprietor, a partner in a partnership or a 2-percent S corporation shareholder
- A worker described in 26 U.S.C. Section 3508

To determine its workforce size an employer adds its average number of full-time employees (FT) in the preceding calendar year to the average number of full-time equivalent employees (FTE) in the preceding calendar year.
FT Counting Instructions: For each month of the preceding calendar year, total the number of employees working an average of 30 hours or more per week during the calendar month or 130 hours or more during the calendar month. Divide the yearly total by 12.
FTE Counting Instructions: For each month of the preceding calendar year combine the number of hours of service for all ***non-full-time employees*** for the month, but do not include more than 120 hours of service per employee. Divide the total by 120. Divide the yearly total by 12.

10. How many full-time employees (FT) were in the group during the preceding calendar year (monthly average)? _____

11. How many full-time equivalent employees (FTE) were in the group during the preceding calendar year (monthly average)? _____(if there were no **non**-full-time employees enter zero)

12. Average number of full-time and full-time equivalent employees in the preceding calendar year: _____
    Add the number of FT employees to the number of FTE employees above (Answer to #12= #10 + #11).

13. **To determine eligibility for group coverage,** the employer must employ one common law employee that is **enrolled** in the health benefit plan at the beginning of the plan year. For the following questions, a sole proprietor, a partner in a partnership, a 2-percent S corporation shareholder, or the spouse of a person who is a sole proprietor, a partner in a partnership, or a 2-percent S corporation shareholder is **not** considered a common law employee.
    a. Are all full-time employees offered enrollment? (If no, the employer does not qualify for a group health benefit plan.)
    ☐ No ☐ Yes
    b. How many employees will be **enrolled** in the health benefit plan at the beginning of plan year? _____
    c. Is the employer a sole proprietor, a partner in a partnership, a 2-percent S corporation shareholder, or the spouse of a person who is a sole proprietor, a partner in a partnership, or a 2-percent S corporation shareholder? ☐ No ☐ Yes **(If Yes, see below)**

    - If Yes, does the employer employ at least one employee that will be **enrolled** in the health benefit plan at the beginning of the plan year who is **not** a sole proprietor, a partner in a partnership, a 2-percent S corporation shareholder, or the spouse of a person who is a sole proprietor, a partner in a partnership, or a 2-percent S corporation shareholder?
      ☐ No ☐ Yes

If you plan to change the group's contribution or eligibility hours on your renewal date, please contact your insurance producer or Sales Representative.

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	Date
Print name	Title
Email	Group ID

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