Health Insurance Renewal for Employers

The purpose of this form is to provide company and health insurance policy information to Cover Oregon, upon request, to determine eligibility for the Cover Oregon employer program.

Requested effective date:			**Group #:**
COMPANY INFORMATION			
Company legal name:		Company DBA name:	
Address:			
City:		State:	ZIP code:
Mailing address *(if different from above):*			
City:		State:	ZIP code:
Name of owner or president:		Title:	
Headquarters location: City:		State:	ZIP code:
EIN *(Federal Tax ID):*	NAICS #:		SIC #:
Business type: ☐ C-Corp ☐ S-Corp ☐ Partnership ☐ Non-profit ☐ 1040 Schedule C Business *(self-employed)* ☐ Tax-exempt Corp. ☐ Tax-exempt Trust ☐ Tax-exempt LLC ☐ Tax-exempt Assoc.			
PRIMARY CONTACT/SECONDARY CONTACT			
Primary contact name *(first, middle, last):*		Title:	
Email address:	Phone #:		Fax #:
Secondary contact name *(first, middle, last):*		Title:	
Email address:	Phone #:		Fax #:
AGENT INFORMATION			
Name *(first, middle, last):*			Agent Oregon license #:
Address:			
City:		State:	ZIP code:
Email address:	Phone #:		Fax #:

DESIGN YOUR COVERAGE AND EMPLOYER CONTRIBUTION AMOUNTS

Who would you like to cover? ☐ Employees only **OR** ☐ Employees and dependents

*Employers with 50 or more employees **cannot** select "Employees only."*

How much will you contribute toward medical and dental premiums?

Medical: Employer will contribute toward employee premium........................ $_____ or _____%

Employer will contribute toward dependent premium .... $_____ or _____%

Dental: Employer will contribute toward employee premium........................ $_____ or _____%

Employer will contribute toward dependent premium .... $_____ or _____%

Currently enrolled in: ☐ Medical ☐ Dental **OR** ☐ Both

Medical carrier:	Plan name:
Medical carrier:	Plan name:
Medical carrier:	Plan name:
Medical carrier:	Plan name:
Medical carrier:	Plan name:
Dental carrier:	Plan name:
Dental carrier:	Plan name:

PREMIUM

Type of coverage	Premium
Employee only	$
Employee/spouse	$
Employee/family	$
Employee/child(ren)	$

ADDITIONAL COMPANY INFORMATION

Please provide additional information about your company in the fields below.

Total number of eligible employees:	Total number of employees on payroll:

What are your weekly eligibility hours? *(17.5 minimum to 40 hours maximum)*

What is your new hire probationary period?

First day of the month following: ☐ date of hire ☐ 30 days ☐ 60 days

Or ☐ 90 days

INSURANCE COMPANY:

Email the completed form to Cover Oregon's Account Management Team at Account.Management@CoverOregon.com