AOI HEALTHCHOICE

AKT BENEFIT ADVISORS LP
Personal. Local. Global.

EMPLOYER APPLICATION AND PARTICIPATION AGREEMENT

EMPLOYER INFORMATION

Legal Name of Employer:	Federal Tax ID No.:	Effective Date:	Anniversary Date:

Are you a current member of AOI: ▯ Yes ▯ No | AOI Membership Number:

# of Eligible Employees: ____ Total # of Employees:_____
Please check the appropriate box for total # of employees including full-time, part-time, or seasonal:
▯ 0-19 ▯ 20-99 ▯ 100+
Please note: Federal regulations require that you must promptly notify Health Net if the number of employees changes from 1-19, 20-99 or 100+.

If you are part of a multi-employer group health plan, has CMS approved a Small Employer Exception for your group?
▯ Yes ▯ No

Name and Title of person responsible for benefit decisions:	Phone No.: ( )	Fax No.: ( )

Address:	Percentage of Employees working in Oregon: ________%
Street:	Nature of Business:
City: State: Zip Code: County:	SIC Code:

E-mail and/or website address:

SELECTION OF MEDICAL BENEFITS

Please select from the carriers and benefit plans shown below. All employees must be enrolled with one carrier. Once you have selected a benefit plan for your group, you may not change your selection until your next renewal.

▯ **Health Net Health Plan of Oregon, Inc. ***

▯ PPO 500 ▯ PPO 1000 ▯ PPO 2000 ▯ PPO 5000 ▯ HSA 1500 ▯ HSA 2500

RX Options (Not available for HSA)

▯ $15/$30/$50 RX ▯ $10/$50/$75 RX

▯ Enhanced Choice Products with $15/30%/50% RX $5000 Max. (Includes $750, $1000, $1500 Deductible Options.)

▯ **Kaiser Permanente**

▯ HMO $15 ($10/$20 RX) ▯ HMO $20 ($10/$20 RX) ▯ HMO 250 ($15/$30 RX)

▯ HMO 500 ($15/$30 RX) ▯ HMO 1000 ($15/$30 RX) ▯ HSA 2600 ($15/$30 RX)

VISION COVERAGE

The AOI Health*Choice* Vision Rider is an employer-choice option (i.e., if vision coverage is elected, all covered employees will receive vision coverage through the health plan in which they enroll for medical coverage).

▯ Yes, I would like to elect vision coverage ▯ No, I choose not to elect vision coverage at this time

(The election of this coverage is allowed only upon initial enrollment or during the group's annual open-enrollment period.)

DENTAL COVERAGE

Please select from the carriers and benefit plans shown below. (Note: If your company has not had 24 months of prior dental coverage, you must choose the Value Plan. Please provide proof of prior dental coverage upon submission of enrollment materials.)
The Kaiser Dental options are available only with the purchase of medical.

Choose Carrier:
▯ Advantage ▯ Kaiser

Choose Plan:
▯ Preferred Plan ▯ Standard Plan ▯ Value Plan

Name of prior carrier: ____ Prior Carrier Group #: ____________________

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HEALTH*CHOICE*

Prior coverage begin date: ____________________ End date: _____________________

CURRENT COVERAGE

Prior to enrolling in AOI Health*Choice*, what medical coverage was in effect? (*check all that apply*):

☐ No prior coverage ☐ Self-Insured ☐ Insured

Name of prior carrier: ____ Prior Carrier Group #: ____________________

Prior coverage begin date: ____________________ End date: _____________________

EMPLOYER CONTRIBUTION

AOI Health*Choice* requires a minimum employer contribution of 50% of the Employee Only rate of the chosen plan.

Amount to be paid by Employer:

For Employee Only Coverage	_______________________%	or	$______________________________
For Employee + Spouse Coverage	_______________________%	or	$______________________________
For Employee + Child(ren) Coverage	_______________________%	or	$______________________________
For Employee + Family Coverage	_______________________%	or	$______________________________

ELIGIBILTY

Employees: Regular active full-time employees scheduled to work at least ___ hours/week. *(Must be at least 17.5 hours.)*

WAITING PERIOD

AOI Health*Choice* allows employers the opportunity to determine waiting period. **Select One**: Coverage will become effective on the 1st day of the month following:

______ Date of Hire _____ 60 days After Date of Hire

______ 30 days After Date of Hire _____ 90 days After Date of Hire

Note: If you have more than one class of eligible employees and want to select different waiting periods for each class, please check here and describe on the back of this form. ❐

COBRA ADMINISTRATION

Employers with 20 or more employees may elect to have AOI Health*Choice* administer COBRA for eligible employees/dependents. If you are an employer with 20 or more full or part time employees, would you like AOI HealthChoice Administrators to administer COBRA for eligible employees/dependents?

❐ Yes ❐ No

If yes, please indicate the total number of employees in your company __________

BILLING INFORMATION

Name and title of person responsible for billing and accounting:

Phone No:
(   )

Address (*if different from page 1*):

Street:

City: State: Zip Code: County:

E-mail and/or website address:

PRINCIPAL EMPLOYEES

List the names of Principal Employees electing 24 hour coverage, (i.e., legally waiving Workers' Compensation coverage). The name of each employee eligible for 24 hour coverage must be listed below for 24 hour coverage to be effective:

____ ____

INSURANCE PROFESSIONAL INFORMATION (Broker/Agent)

I hereby designate the following as my insurance professional (Broker/Agent) of record as of the initial effective date of coverage under AOI Health*Choice* plans.

Address:	City:	State:	Zip Code:	Phone No.:	Fax No.:
				( )	( )

Please indicate to whom commissions should be made payable:

E-mail address:

AUTHORIZATION

I certify, to the best of my knowledge, the information reported above is true and accurate. I also (further) certify that I have read and comply with AOI Health*Choice* Participation Policies. I further acknowledge that this employer is responsible for premium payments due while AOI Health*Choice* insurance coverage associated with these elections are in effect.

Employer Representative Signature/Title:____ Date:____________________

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. AOI reserves the right to accept or deny participation in AOI Health*Choice* based on consistency with AOI Health*Choice* participation and administrative policies.

* Health Net Health Plan of Oregon, Inc., 13221 SW 68th Parkway, Tigard, Oregon 97223 • 888-802-7001 • www.healthnet.com

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