# EMPLOYER APPLICATION AND PARTICIPATION AGREEMENT
## FOR HEALTH PLAN PARTICIPATION

**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:_____ |
| 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 of Oregon**
- **Kaiser Permanente**

**Plan Options**

Package A Package B Package C Package D Package E Package F

**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 a benefit level: **(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.)**

Preferred Plan Standard Plan Value Plan

**Name of prior carrier:** ______________________________________________ Prior Carrier Group #: _________________

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 | $______________________________ |

| WAITING PERIOD | COBRA ADMINISTRATION |
|---|---|
| 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:<br><br>_____ Date of Hire    ____ 60 days After Date of Hire<br><br>_____ 30 days After Date of Hire    ____ 90 days After Date of Hire<br><br>**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. ❒ | 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?<br><br>❒ Yes    ❒ No<br><br>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:<br>( ) |
|---|---|

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.

| Name: | Name of Firm: | | | | |
|---|---|---|---|---|---|
| Address: | City: | State: | Zip Code: | Phone No.:<br>( ) | Fax No.:<br>( ) |

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.