

Dear Employer:

You may have employees now or in the future who apply to the state Family Health Insurance Assistance Program (FHIAP) for help paying their share of the health insurance premium. FHIAP helps uninsured Oregonians afford private health insurance. We need information about your health benefits to determine whether your employee can use a FHIAP subsidy to enroll in your health plan. If you have questions about this form, please call the benchmark specialist at 888-564-9669. Or, e-mail: [mas.fhiap@state.or.us](mailto:mas.fhiap@state.or.us)

**Reason for sending FHIAP this form:**

- An employee asked me to fill out this form so he/she can apply to FHIAP
- I want to know if my plan meets the benchmark so I can share FHIAP with my employees in the future
- My benefits just changed and I need to “benchmark” the new plan

Employee name (if applicable):	Reservation number (if known):	
Employer name:	Employer Identification Number (EIN):	
Employer address:	Industry:	
City:	State:	ZIP:
Benefit contact person:	Contact phone number:	
Address:	Fax number:	
City:	State:	ZIP:
Benefit contact person’s e-mail:		

***Please make a copy of this form for each medical and prescription plan offered.***

Health Insurance Company: \_\_\_\_\_ Plan purchase pending?  Yes  No

**Policy number?** \_\_\_\_\_

(If a plan purchase is pending, please provide the number as soon as possible.)

**What type of health benefit plan is offered or being purchased?**

- Traditional-indemnity  Preferred Provider Option (PPO)  Health Maintenance Organization (HMO)
- Point of Service (POS)  Exclusive Provider Option (EPO)  Other *(please specify)* \_\_\_\_\_

In which month do you conduct annual open enrollment? \_\_\_\_\_

How often does the employer change the plan benefits?  Annually  Other (please specify) \_\_\_\_\_

If benefits are changed annually, in which month does the change take effect? \_\_\_\_\_

**This is not the FHIAP application. Call 888-564-9669 and ask for marketing to request applications for your employees.**

Does the employer contribute to the premium for **employee** coverage?  Yes  No  
If yes, how much is contributed (approximate dollar amount)? \_\_\_\_\_

Does the employer contribute to the premium for **dependent** coverage?  Yes  No  
If yes, how much is contributed (approximate dollar amount)? \_\_\_\_\_

Is anyone in this family currently enrolled in your health benefit plan?  Yes  No  
If yes, who? \_\_\_\_\_ Effective date: \_\_\_\_\_

Original effective date of coverage in employer's health insurance plan for employee: \_\_\_\_\_ Family: \_\_\_\_\_

Please attach the following:

- Rate sheet showing all combinations (employee, employee/spouse, family, etc.) You will be asked specific information about the employee on an Enrollment Verification (EV) form. If the plan purchase is pending, please send the information as soon as it's available.
- Copy of **both** the **Medical and Prescription Summary Plan Description** or the **Benefit Booklet** provided by the health insurance company. We need a copy for each plan you offer.

Once your plan is reviewed and approved, we won't need to see additional copies of the benefit information until next year, unless there is a change in the health benefits. If your health benefit plan meets our benchmark and is eligible for a FHIAP subsidy, you will receive an Enrollment Verification Form to complete for each approved employee or family.

However, after reviewing the materials, we may need more information about your benefits. If you sign below, we can contact the health insurance carrier or plan administrator directly for answers to our questions.

### **Authorized Permission**

The Family Health Insurance Assistance Program (FHIAP) has my permission to contact my health insurance carrier or plan administrator to get information needed to determine whether my company's benefit plan may be subsidized.

Signature of FHIAP applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Employer name: \_\_\_\_\_

You may return this form and plan information directly to FHIAP. Or, you may give it to an employee to include as part of an application.

### **FHIAP**

Attn: Benchmarking

P.O. Box 5880

Salem, Oregon 97304-0880