OAR 443-005-0070(4)(B), EXHIBIT 1

Oregon Medical Insurance Pool
Assessment Reduction Application & Worksheet – Page 1

Company Name: ____________________ Company Address: ____________________
DCBS #: __________ ____________________

This application applies only to individual health insurance plans sold in Oregon and is reported quarterly by an insurer that has voluntarily elected to participate in the OMIP Assessment Reduction Program, as defined in OAR 443-005-0070. The following criteria must be met before the health insurance carrier, herein referred to as insurer, will be eligible for the assessment reduction program. Circle the appropriate response to the following questions:

1. Is the insurer active in Oregon's individual health insurance market in the same or greater areas as its group plans?

   Yes / No / Does Not Apply

2. If the insurer is ONLY in the individual health insurance market, does the insurer offer the individual health insurance plans statewide?

   Yes / No / Does Not Apply

3. The insurer must offer at least one individual insurance plan that has a scope of benefits similar to OMIP with member cost sharing actuarially equivalent to at least one OMIP plan. Does the insurer offer such a plan? *Please provide OMIP a copy of the contract and premium schedule for the selected plan.*

   Yes / No / Does Not Apply

4. Rates for the plan submitted, when averaged over a two-year period, must be less than the OMIP surcharged rate. Do the insurer's rates meet these criteria?

   Yes / No / Does Not Apply

5. The insurer must demonstrate an active marketing plan for all individual health insurance plans and all plans must be continuously available. This includes plans in any specific market segment. Does the insurer actively market its individual plans and are they continuously available?

   Yes / No / Does Not Apply

Oregon Medical Insurance Pool
Assessment Reduction Application & Worksheet - Page 2

Please fill in the following table for the three months reporting. The table applies only to individual health insurance sold in Orego

(A) Month/Year Reporting	(B) Applications Received	(C) Applications Accepted	(D) Applications Rejected for Health Reasons	(E) Applications Rejected for Other Than Health Reasons	(F) Applications Rejected for Existing Pregnancy	(G) Rejection Rate D/(C+D)
Quarter Totals						

I certify that all the statements and information in this application are true and correct and that I have the authority execute and file this application for assessment reduction. I take notice of the prohibition under ORS 731.260 against false or misleading information filed with the Director of the Department of Consumer and Business Services

Signature of Officer　　　　　　　　　　Name and Title

Date　　　　　　　　　　Telephone Number

Submit the application, worksheet and other required documents to OMIP no later than the 30 days following the quarter being reported. This form and other required documents may be mailed or faxed to OMIP.

OMIP Address: 250 Church Street SE #200
Salem, Oregon 97301-3921

OMIP Fax: (503) 378-8365
OMIP Phone: (503) 373-1692