



Group Insurance Information

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 1-888-564-9669. Or, e-mail: fhiap.mail@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:	Federal 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 email:		

If you offer multiple plans, please make a copy of this form for each plan.

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 1-888-564-9669 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 (either the percentage or approximate dollar amount)? _____

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

Is anyone in this family currently enrolled in your health benefit plan? Yes No
If yes, who? _____

Effective date: _____

Please attach the following:

- Rate information (quote, invoice, prepared worksheet, etc.) 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 the **Summary Plan Description** or the **Benefit Booklet** provided by the health insurance company. We need a copy for each plan you offer. Please be sure the information provided includes **prescription** benefit information.

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 employer representative 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