Association Health Plan Filing Transmittal

Filing Requirements

Applies to Group Health Benefit Plan Coverage to be issued to a group or association of employers.

When issuing group health insurance that is not a health benefit plan within the meaning of ORS 743B.005 to an Association, Union Trust, Trust Group, Credit Union, or fully insured Multiple Employer Welfare Arrangement (MEWA), please complete form 440-2441A.

Note - This form should be used when issuing coverage to *fully insured* Multiple Employer Welfare Arrangement (MEWA).

If you are interested in filing a NEW self-insured MEWA contact Rick Barry at rick.a.barry@dcbs.oregon.gov.

Limits Only one group or association of employers is permitted per filing.

CONTACT INFORMATION

Insurer Contact Information
Insurer Filing Contact: _____ Title: _____
Filer Phone Number: _____ Email: _____

Insurer Group Market Contact: _____ Title: _____
Filer Phone Number: _____ Email:_____

Agent Contact Information
Lead Agent Contact: _____ Agency: _____
Agent Phone Number: _____ Email: _____

Association Contact Information
Group Contact: _____ Title: _____
Phone Number: _____ Email: _____

ASSOCIATION INFORMATION

Provide information about the group or association of employers. The information provided in this section should match information as it appears on the bylaws, trust documents, or other legal records.

Name of the Association: _____

Primary Business Address (headquarters): _____

Primary Mailing Address (if different): _____

State where association was incorporated or formed: __

Group Number Assigned by Oregon Insurance Division (if known): ____

Primary Website Address (If social media is used as a business website, please identify the social media account and platform): _____

1. Does the association offer (or plan to offer) non-health benefit plan coverages, including miscellaneous health or life insurance, to its membership?
   ☐ Yes ☐ No
   If yes, list the other types of coverages and, if known, the company that underwrites that coverage. _____

2. Does the association offer health benefit plans from multiple insurers? If yes, please list the other insurers who offer (or are expected to offer) health benefit coverage to the association. _____

The full legal name of the policyholder, as will be recorded on the policy document (if coverage will be issued to a trust or the trustees of a trust established by the association, enter the name of the trust or trustees): _____

CONSTITUTION AND BYLAWS

Under ORS 731.098, group health insurance may be issued to an association that has an active existence for at least one year and that has a constitution and bylaws.

1. Has the association been in active existence for at least one year?
   ☐ Yes ☐ No
2. Does the association have a constitution and bylaws?
   ☐ Yes ☐ No

Copies of the constitution and bylaws should be included with this filing. If the constitution and bylaws do not clearly establish the date the association was founded, the filing should also include documentation demonstrating that the association has been in active existence for at least one year (e.g. articles of incorporation).

STATEMENT OF PURPOSE

Under ORS 731.098, an association must be organized and maintained in good faith primarily for purposes other than obtaining insurance. Provide an explanation describing the purpose of the association. You may attach additional pages if necessary. _____

EMPLOYER ELIGIBILITY

Provide a complete statement describing the requirements for an employer to become a member of the association and to remain in good standing, including the amounts of any dues or membership fees. If this information is contained in the application, ERISA letter, bylaws, or other materials, you may attach copies of those materials or refer to the specific section of filed documents that address eligibility and refer to them in the statement.

1. Are all employer members of the association eligible to participate in the group health benefit plan?
   ☐ Yes ☐ No

   If no, the statement of employer eligibility should clearly describe any additional requirements an employer member must satisfy in order to participate in the health benefit plan.

2. Does the association offer different tiers of membership (e.g. premium and standard memberships)?
   ☐ Yes ☐ No

   If yes, the statement of employer eligibility should describe the eligibility requirements for each tier or level of membership and indicate which tiers or membership are eligible to participate in the health benefit plan.

3. Is membership in the association limited to a particular trade, business, or industry?
   ☐ Yes ☐ No

   If yes, the statement of employer eligibility should identify the trade, business, or industry served by the association and describe how the association determines whether a particular employer is engaged in that trade, business or industry.

4. Does the association accept employer members from throughout the state of Oregon?
   ☐ Yes ☐ No

   If no, the statement of employer eligibility should clearly define any geographic restrictions on employer membership (e.g. employers must be headquartered in particular counties or zip codes).

5. When evaluating employer member eligibility, does the association consider the health status of an employer's workforce?
   ☐ Yes ☐ No

6. When selecting employer members, does the association consider the individual health status of particular employees or dependents for eligibility to enroll in the health benefit plan?
   ☐ Yes ☐ No

7. Does the association allow “working owners” (e.g. sole proprietors and self-employed individuals who do not employ at least one common law employee) to participate in the health benefit plan?
   ☐ Yes ☐ No
   If yes, will coverage issued to working owners through the association satisfy Oregon requirements for individual health benefit plans, including rating and benefit requirements?
   ☐ Yes ☐ No

8. Does the association accept employer members who are small employers (at least one but not more than 50 employees)?
   ☐ Yes ☐ No

9. Does the association accept employer members who are large employers (51 or more employees)?
   ☐ Yes ☐ No

ENROLLEE ELIGIBILITY

Provide a complete statement describing who will be eligible to enroll in the health benefit plan coverage that will issued to the association (e.g. employees of member employers and their dependents). The statement should include **all** terms and conditions applicable to enrollees, including any requirements for continued eligibility that will be set by the carrier or by the employer association (e.g. “hours worked” requirements)..

1. Will dependents (spouses and children of eligible individuals) be eligible to enroll?
   ☐ Yes ☐ No

   If yes, the statement of enrollee eligibility should include any requirements for dependent eligibility.

COMMONALITY AND CONTROL

Does the group qualify as a bona fide group or association of employers within the meaning of ERISA § 3(5)
☐ Yes ☐ No

If yes, the filing must include a letter from an attorney that concludes that the employer association qualifies as an employer under 29 U.S.C.1002(5). The letter must explain the basis for its conclusion using, at a minimum, the following criteria:

1. *Commonality of Interest* – The employer association sponsoring and the individuals benefitting from the group health benefit coverage are tied by a common economic or representational interest beyond the provision of health insurance, considering:
   a. How employer-members of the employer association are solicited;
   b. Eligibility criteria to participate in the employer association;
   c. The process by which the employer-association was formed;
   d. The purpose for the formation of the employer association; and
   e. Preexisting relationships of any of the employer-members of the employer association.

2. *Control* – The members of the employer association that participate in the group health benefit coverage will exercise control, in both form and in substance, over the administration and operation of the group health benefit coverage.

TRUST INFORMATION

1. will coverage be issued to the trustees of a fund established by the association?

☐ Yes ☐ No

If no, you may leave the remaining questions blank and proceed to the next section.

2. A copy of the trust document is included under supporting documentation.

☐ Yes ☐ No

Name of the trust _____

3. Who established the trust?

_____

4. State where trust was established? _____

FORMS ISSUED TO THE GROUP

In the table below, provide form numbers of policies, certificates, applications and any other form to be issued to the group.

Form number	Product or form type	Negotiated (Y/N) If no, provide the State Filing number in which the forms were approved in next column (ORS 742.003 and Bulletin 98-3)	SERFF tracking number

_____	_____	_____
Signature	Title/Role	Date

_____

Name (Print)