Welcome
Thank you for choosing ODS.

New Group Enrollment Checklist for Employers and Agents

Please forward the following to ODS, Attn Marketing Department: *(address provided below)*

- ☐ Group Application - Completed and Signed by Group and Agent
- ☐ Enrollment Forms / Waiver Forms for All Eligible Employees
  (include hire dates on all enrollment forms)
- ☐ First Month's Premium (make check payable to ODS)
- ☐ ACH (automatic payment) Authorization Form - if applicable
- ☐ Last Month's Bill: (Medical Only)
  Claims may be placed on hold until a Last Month's Bill is received, in order to apply pre-existing information. Not applicable if the group did not have prior coverage.

For Medical groups with 2-4 employees only, please provide one of the following:

- ☐ Alaska Quarterly Contribution Report
- ☐ Federal Form 1065
- ☐ 1040 Schedule C with W-2's

Enrollment Process Timeline:

All new group information must be received by ODS to initiate the enrollment process. Submission of paperwork should be completed by the 20th of the month, prior to the effective date, in order for members to receive ID cards in a timely manner. For new group information received after the 20th, ODS may require up to 10 business days to complete the enrollment process. Member handbooks and ID cards are mailed from Portland, Oregon. Variation in mailing schedules can affect the arrival of these materials.

Sending Paperwork to ODS:

All new group information should be sent to the ODS Alaska Marketing Team:

ODS Alaska
Attn: Marketing Department
601 W Fifth Avenue, Suite 510
Anchorage, AK 99501
(907) 278-2626 or toll free 1-888-374-8910
(907) 278-2900 fax

Member Handbooks

ODS encourages our members to view their handbooks online at www.odsalaska.com

How many printed ODS member handbooks would you like? _____

Alaska Group Application
2-50 Employees

Effective Date: _____
Renewal Date: _____
Type: _____

GROUP INFORMATION

Legal Name _____

Street Address _____ City/State/Zip _____

Billing Name _____
(if different from above)

Billing Address _____ City/State/Zip _____
(if different from above)

Group Administrator _____ Billing Contact _____

Phone # _____ Phone # _____

Fax # _____ Fax # _____

Email Address _____ Email Address _____

Employer Tax ID # _____

CONTRIBUTION & PARTICIPATION

Employee Participation

Medical and dental integrated or medical only plans: for groups of 2 – 9 employees, 100% of eligible employees must participate.
Medical and dental integrated or medical only plans: for groups of 10 – 50 employees, 75% of eligible employees must participate.
Dental stand alone plans: for groups of 5 – 50 employees, 100% of eligible employees must participate.
Employees waiving off for other verifiable coverage or employees on probationary/eligibility period do not count against participation.

Dependent Participation

Medical and dental integrated or medical only plans: for groups of 2 – 9 employees, 100% of eligible dependents must participate.
Medical and dental integrated or medical only plans: for groups of 10 – 50 employees, 25% of eligible dependents must participate.
Dental stand alone plans: for groups of 5 – 50 employees, 100% of eligible dependents must participate if the dependent contribution is 100%. Otherwise, 75% of eligible dependents must participate.
Dependents waiving off for other verifiable coverage do not count against participation.

Contribution

Medical and dental integrated or medical only plans: Employer must contribute at least 50% toward the employee premium.
ODS does not require contribution toward the dependent premium except for dental stand alone plans for groups of 5 – 9 employees.
For these groups, the employer must contribute at least 50% toward the employee premium and at least 25% to the dependent premium.

1. What percentage of your medical premium is contributed by the employer?
   Employees (minimum 50%) _____ Dependents _____
2. What percentage of your dental premium is contributed by the employer?
   Employees (minimum 50%) _____ Dependents _____
3. If enrolling in an ODS dental plan, can employees and their dependents enroll in the dental plan without enrolling in the group's medical plan, regardless if ODS is or is not the medical carrier? (Y/N) _____
   (Yes = Standalone; No = Integrated)

ELIGIBILITY

1. How many hours per week must employees work to be eligible for benefits? (minimum 20 / week) _____
2. What is the eligibility period employees must complete before being eligible for benefits?
   The first of the month following: _____ **OR** ☐ Date of Hire with Mid Month Pro Rate
   OR Coverage begins following _____ days of employment with the Group.
   ☐ One Time - Waive probationary period for members enrolling for new group only
3. Does the eligibility period apply to all classification of employees? If no, explain in comments. (Y/N) _____
4. What is the effective date of changes made during your open enrollment if different than your renewal month? (mm/dd) _____
5. What month does the group's Fiscal year begin? _____
6. Does your group represent or belong to an association or trust? (Y/N) _____
7. Is Domestic Partner coverage available? (Y/N) _____
8. Is your group subject to a bargaining (union) agreement? If yes, please complete the following (Y/N) _____

   What is the effective date of the agreement? _____

   What is the expiration date of the agreement? _____

ODS Alaska

ALASKA STANDARDIZED GROUP PROFILE FORM

This information must be collected for all new and renewing groups to determine whether the group qualifies as a small employer.

If you are requesting coverage as a single group because you are an affiliated group of employers for the purpose of pension plans under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, ODS will treat the affiliated group as a single group and the affiliated group must fill out one group profile form. If you are an affiliated group of employers but are not requesting coverage as a single group, each employer group in the affiliated group must fill out a separate group profile form.

SECTION A

EMPLOYEE ONLY PLAN?	☐ Yes ☐ No
EMPLOYEE + DEPENDENT PLAN?	☐ Yes ☐ No

1. Average number of employees during the preceding calendar year: If the average number of employees is 51 or greater, the group may qualify as a large group (see Section B for more information). If the average number of employees is at least 2 but not more than 50 during the preceding calendar year and you have at least 2 but not more than 50 eligible employees as of the date coverage is to take effect, you are a small employer.		
2. Did more than 50% of the average number of employees work in Alaska during the preceding calendar year?	☐ Yes ☐ No	
3. To determine if your group is subject to COBRA, indicate how many employees you employed on a typical business day in the previous calendar year: Do not count self-employed individuals, independent contractors, and members of the board of directors. (If the group had 20 or more employees during at least 50% of the previous calendar year, the plan qualifies for COBRA continuation.)		
4. Number of *eligible* employees as of the date coverage is to take effect: This is the number of employees who work a regular schedule of 20 hours or more per week on the date coverage is to take effect. Eligible employees do not include employees who work on a temporary, seasonal or substitute basis.		
5. Out of the number of eligible employees indicated in question #4, indicate the number of employees *not* eligible for coverage due to *group's eligibility rules* :		
6. Total number of group eligible employees *(#4 - #5)* :		
	Medical	**Dental**
7. Out of the number of employees indicated in question #6, indicate the number of employees waiving due to other creditable coverage (group or individual):		
8. Total employee count (for participation requirement): *(#6 - #7)*		
9. Out of the number of employees indicated in question #7, indicate the number of employees opting out of coverage: Count only employees who choose not to take coverage and they do not have other creditable coverage (group or individual).		
10. Total number of employees enrolling *(#8 - #9)*		
11. Total number of COBRA Enrollees (include primary insured's only):		
12. Total number of employees and COBRA enrollees enrolling *(#10 + #11)* :		
13. What type of employees are you offering coverage to: **a. All employees regardless of hours worked** **b. All employees working 20 hours or more per week** **c. All employees working the minimum hours required by your specific company in order to qualify for benefits (i.e. 40 hours per week)** **d. Only a certain classification of employees (i.e. Management only, Salaried only, etc.)*** ***If you chose "d" as the answer to this question, please explain in the comments below.**		

Comments:

EMPLOYEE PARTICIPATION	Medical	Dental
14. What percentage of *employees* participate in the plan(s)? *(#10 divided by #8)*		

DEPENDENT PARTICIPATION

If you checked "yes" to EMPLOYEE ONLY PLAN on page 1, please mark "N/A" for dependent participation in question #15 below. Please note that under an employee only contract, ODS will not allow any future dependents to be covered on this plan.

If you checked "yes" to EMPLOYEE + DEPENDENT PLAN on page 1, but currently have no eligible dependents to enroll, please indicate 0% for dependent participation in question #15 below. Please note that under an employee + dependent contract, ODS will allow any future dependents to be covered on this plan.

If you checked "yes" to EMPLOYEE + DEPENDENT PLAN on page 1, and currently have eligible dependents to enroll, please calculate your current dependent participation and indicate this percentage in question #15 below. Please note that under an employee + dependent contract, ODS will allow any future dependents to be covered on this plan.

	Medical	Dental
15. What percentage of *dependents* participate in the plan(s)?	**%**	**%**

SECTION B

Disclosure Notice for Employers

If an employer has an average of more than 50 employees during the preceding calendar year, ODS may provide the employer a health insurance quote as a large group. However, ODS must treat an employer as a small employer and must provide a quote only on that basis if both of the following conditions apply:

(1) The employer's workforce consists of at least two but not more than 50 eligible employees as of the date coverage is to take effect; and

(2) Coverage is limited to eligible employees.

To the best of my knowledge, I certify that all the information contained herein is correct. I understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted and that additional information may be required to verify eligibility of the group.

I am the: ☐ Group Administrator ☐ Business Owner ☐ Authorized Insurance Agent ☐ Other _____

Name (printed please) **Signature** **Date:**

COBRA: *(when applicable)*

To determine if your group is eligible for COBRA, use the group profile form on the previous page. If the number to question 3 is 20 or greater your group is eligible for COBRA. ODS subsidiary, BenefitHelp Solutions (BHS), provides COBRA Administration at no additional cost to ODS Medical Groups. If electing to use BHS to administer your COBRA mark Yes for question 1.

1. Do you use a COBRA Third Party Administrator (TPA)? : ***(Y/N):*** _____

1a If yes, enter TPA Name and contact information: Name of TPA: _____

Mail COBRA bill to: _____ Contact: _____

1b Coverage/Product lines the TPA is used for: Phone:

BHS provides a Premium Contribution Plan (PC-EZ) at no additional cost to ODS groups.
More information is available regarding BenefitHelp Solutions COBRA Administration or the Premium Contribution Plan. Refer to page 6 of this application.

PC-EZ (Premium Contribution Plan)

1. If group is eligible for COBRA or has elected medical coverage and is size 2-99 the group has the option to enroll in the Premium Contribution Plan.
Will the group enroll in the PC-EZ plan through BHS? ***(Y/N):*** _____

TYPES OF COVERAGE

Medical Plan Design # _____ ☐ Hearing Aid Rider

1 Is ODS to cover your out of state employees? (Y/N) _____

If Yes, list state(s) and number of employees in each state: _____

(Out of State Provider Network: ODS Select)

Prescription Drug (Rx) Design # _____

Vision Plan Design # _____

Dental Plan Design # _____

Orthodontia Plan Design # _____

(Orthodontia is available to groups with a minimum of 26 or more employees enrolling.)

EXISTING COVERAGE

1. Please provide the name of your current carrier(s), dental and medical:

Medical _____ Dental _____

2. If this plan is replacing an existing plan, will members receive deductible credit from previous plan? ***(Y/N):*** _____

If Yes, check type of report that will be available.

Medical ☐ Explanation of Benefits (EOB) ☐ Other _____

Dental ☐ Explanation of Benefits (EOB) ☐ Other _____

3. If enrolling in Dental Plan A (incentive plan) will members covered on the group's prior plan restart benefits at the first year's benefit level? (Yes/No/NA) _____

If No, check benefit level to apply for existing members:

☐ Current Level: need report ☐ % to bring all members - need report ☐ Accumulator Transfer

(Accumulator Transfers include benefit level, limits on services, calendar year maximums)

RATES	**EE**	**EE + Sp**	**EE + Family**	**EE + Child**	**Total**
Employee Counts					
Medical					
Hearing Aid Rider					
Pharmacy					
Vision					
Subtotal Medical					
ODS Employee Counts					
Dental					
Ortho					
Subtotal ODS Dental					
Subtotal ODS					
Total Billed					

PAYMENT

1. Will the group make payments via Automatic Clearing House (ACH) or by check?

☐ Check ☐ Automatic Payment - ACH

If automatic payment, please include ACH authorization form, voided check and a check for the 1st month's premium.

AGENT INFORMATION

AGENT 1		Tax ID / SS #	
Agency		Phone #	
Comm. Address		Fax #	
City/St/Zip		Email Address	
Physical Address		License #	
City/St/Zip		Split Commission	

I hereby make application to ODS, on behalf of the Group, for the Group Policies indicated above. I understand there is no coverage in effect until ODS accepts this Application and premium deposit, and establishes an effective date. If this Application is not accepted, the premium deposit will be refunded.

I hereby certify all eligible employees are enrolling in the selected Group Policies and all enrolling employees meet the eligibility requirements specified above. I hereby acknowledge receipt of the Outline of Coverage Form provided by ODS. In addition, I hereby appoint the above agent as our Agent of Record to represent us in matters of group insurance benefits provided by ODS. This appointment is in effect on the same day as this Application and will remain in force until rescinded in writing.

For Medical groups only:
In addition, I hereby acknowledge responsibility on behalf of the Group to provide the Initial Notice of HIPAA Special Enrollment Rights and Exclusion Periods to all employees on or before the date they enroll in the selected Group Policies.

X _____

Authorized Signature for **GROUP** | Authorized Signer's Title

Authorized Signer's Printed Name | Date

X _____

Authorized **AGENT** Signature

Authorized Agent's Printed Name | Date

X _____

Marketing Representative Signature | Date

EMPLOYER ONLINE SERVICES AGREEMENT

(ODS) and _____("CLIENT") are mutually interested in enhancing service to our members. Electronic Services are advanced technologies designed to allow a group administrator or person(s) designated by the same, to review and modify member enrollment and Primary Care Physician designations, order ID cards and perform other group enrollment related funtions for the CLIENT'S employees who are members of an ODS health benefit plan.

The parties agree as follows:

1. Description.

Electronic Services will consist of on line access to limited INFORMATION, the content solely determined by ODS, via a secure electronic connection.

2. Definitions.

a. INFORMATION is defined as benefit plan enrollment information regarding a member including, but not limited to, the member's name, address, phone number, family members, benefit levels, Primary Care Physician and eligibility. INFORMATION shall also include software applications that transmit individually identifiable information of a member.
b. Electronic Services include all ODS computer, telephonic, email or wireless services or systems.
c. Backup Materials are the electronic, written or printed materials through which CLIENT obtained the INFORMATION from its employees. Backup Materials include, but are not limited to, enrollment forms, benefit plan applications, personal data sheets, and any forms required to update or change INFORMATION, whether in written or electronic form.

3. Information.

The INFORMATION is the property of ODS. CLIENT agrees not to retransmit, disseminate, sell, distribute, publish, broadcast, circulate or commercially exploit the INFORMATION in any manner nor use the INFORMATION for any unlawful purpose. This applies to any individually identifiable information whether in written, printed or verbal form.

4. Confidentiality of Information

ODS and Client mutually acknowledge that security and confidentiality of member information, including but not limited to member demographic, health and claims information, are of extreme importance. Client shall maintain the security and confidentiality of such information as required by all applicable state and federal law and:

a. Client will not use or further disclose the information for any purpose except as necessary to carry out this agreement;
b. Client will use appropriate physical, technical and administrative safeguards to prevent use or disclosure of the information other than as provided for by this agreement.

5. Access, Passwords, and Security.

CLIENT agrees to follow the security and privacy protocols established by ODS and described in the Online Reference Documentation to ensure that all Electronic Services transactions are authorized and to protect all member-specific INFORMATION from improper access.

CLIENT will maintain confidentiality of logon identifications and passwords and prevent any unauthorized individual(s) from accessing Electronic Services and/or using INFORMATION in a manner contrary to this Agreement.

6. Reporting Violations.

CLIENT agrees to immediately notify ODS if CLIENT becomes aware of any of the following:
a. Any loss or theft of access codes or passwords.
b. Any unauthorized use of any access codes or passwords.
c. Any unauthorized use of the Electronic Services
d. Any loss, theft or unauthorized use of INFORMATION.
e. Any loss or theft of hardware which contains INFORMATION.

7. Enrollment Materials.

CLIENT agrees to retain all Enrollment Materials, regardless of media, for a period of seven years and, upon request, to provide ODS with reasonable access to such Enrollment Materials.

8. Indemnification.

CLIENT agrees to defend, indemnify and hold ODS harmless from and against any and all claims, losses, damages, liability, costs and expenses (including but not limited to defense costs and attorney fees) arising from CLIENT'S violation of this Agreement, misuse of INFORMATION, or any third-party's rights, including violation of any proprietary right and invastion of any privacy rights. This obligation will survive the termination of this Agreement.

9. Termination.

ODS reserves the right to terminate CLIENT access to Electronic Services or any portion of the services in its sole discretion, without notice and without limitation, for any reason whatsoever, including but not limited to unauthorized use of INFORMATION, failure to adhere to policies set forth in documentation, or breach of this Agreement.

10. Assignment.

CLIENT may not assign its rights, interests or obligations or any part thereof under the Agreement without prior written permission of ODS.

11. Invalidity Due to Change in Law.

This Agreement shall be voidable by either party if it is prohibited by state or federal law or where ruled or adjudicated to be invalid, void or illegal under any current or future federal or state statute or regulation. If any portion of this Agreement is invalid due to such a prohibition, the remainder of the Agreement shall remain in effect. CLIENT agrees to modify the agreement to conform to changes in the applicable rules designated by current or future federal or state statute or regulation, if requested by ODS.

12.Terms of Use.

CLIENT also agrees to abide by the Terms of Use posted on the ODS Web site if using the Web site to access Electronic Services.

13. Entire Agreement.

This Agreement constitutes the entire agreement between the parties, which may be modified only in writing, signed by both parties. There are no promises or representations between the parties other than as stated in this Agreement.

14. Notices.

All notices will be effective when received in writing. Notices to CLIENT will be given at the address shown in this Agreement below, and notices to ODS will be given at 601 SW 2nd Avenue, Portland, OR 97204. Either party can give notice of address change.

By:

William Hockett
Vice-President

15. Acknowledgment.

By signing this Agreement, CLIENT acknowledges that CLIENT has read, understands and accepts the terms and conditions as stated herein and in Electronic Services documentation.

_____
Signature

The individual signing on behalf of the Client must be the owner of the business in a sole proprietorship, a partner in a partnership, or the designated principal in a limited parthernship, corporation or other licensed entity. Examples include: Owner, Officer, Administrator, Human Resources Director.

_____
Printed Name

_____
Title

_____
Date

_____
Tax Identification #

_____
Name of CLIENT

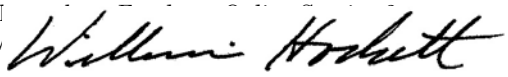
_____
ODS Group Number

_____
Name of Contact Person

The Contact Person is the person within the Client organization who is selected by the Client to authorize user access to Electronic Services.

_____
Contact Telephone Number

_____
Contact E-mail Address

How did you l
Website M  Other: _____

Return the signed agreement to:
Employer Online Services Administrator
ODS Health Plans
PO Box 40384
Portland, OR 97240-0384
Fax 503-948-5577

ODS has partnered with our subsidiary company BenefitHelp Solutions (BHS) to help make your job as a group administrator easier.

It is our pleasure to share with you two services that will be automatically offered at no additional cost with select ODS plan(s).

COBRA Administration

If you enroll in ODS medical & dental plans or a medical only plan and you have between 20 - 99 employees at least 51% of the preceding calendar year, your plan will include comprehensive COBRA administrative services provided by BHS. Through this program, BHS will assist by:

- Collecting premium from members enrolled in COBRA and forwarding to ODS
- Mailing Initial Notification letters
- Mailing Qualifying Event notices
- Mailing Notice of Portability Rights (90-day)
- Providing weekly eligibility reports
- Generating Certificates of Creditable Coverage

Premium Contribution Plan (PC-EZ)

If you enroll in ODS medical & dental plans or a medical only plan and you have 2-99 employees enrolled, your plan will include PC-EZ, a self-administered premium contribution plan. This program complies with Internal Revenue Code (IRC) Section 125 which allows your employees the benefit of using before-tax dollars to cover their portion of premium contribution, thereby allowing the employer to save in payroll taxes. From enrollment forms and Summary Plan Descriptions to nondiscrimination testing of your plan, PC-EZ allows you to quickly and easily begin administering your own IRC Section 125 plan.

Over the course of the next couple of weeks, if you are eligible for COBRA administration and/or PC-EZ, you will receive additional information and an agreement acknowledging your participation in the COBRA Administration and PC-EZ program.