

Insurance Pool Governing Board (IPGB) GROUP CENSUS

For Internal Use Only

Group Number _____

Legal Name of Employer _____

Please list all employees and provide the information requested. This roster is part of your group file. It must be completed, signed and dated by the employer's authorized representative. In lieu of this form, system-generated information is acceptable. Regence BlueCross BlueShield of Oregon may request payroll records for employees listed.

An employee is one who works on a regular scheduled basis, 50% or more during the previous year. The employer determines the waiting (probationary) period for new hires in addition to the number of hours employees must work to be "eligible" for group insurance. Indicate your business requirements below. **See reverse side for field definitions.**

Waiting (probationary) period _____ Number of hours per week employees must work to be eligible for insurance _____

Oregon groups: Average number of employees working 17.5 hours per week or greater in preceding calendar year _____

Employee Legal Last Name	Employee Legal First Name	State of Residence	Employee Birthdate mm/dd/yyyy	Hours Worked Per Week	Date of Hire mm/dd/yyyy	Legal Spouse Yes/No	Number of Dependents (Excluding Emp & Spouse)	Birth Dates of Each Dependent (excluding employee & spouse)	Enrollment Code * Employee	Enrollment Code * Spouse/Dep	COBRA or Cont. - Check if Yes
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*** Enrollment Codes for:**

OR Employee Enrolling: **01** = Employee only **02** = Employee and Spouse **03** = Employee and Child **04** = Employee, Spouse, and Child(ren) **05** = Employee and Child(ren)

Employee and/or Dependent Not Enrolling: **A** = Medicaid **C** = Ineligible Class **F** = Contracted Employee (i.e., temporary Bookkeeper) **G** = Other Group Insurance **H** = Hours Insufficient **I** = Other Individual Coverage

M = Medicare/OMIP Coverage **P** = Waiting Period Not Served **S** = Spouse of another Employee **V** = Veteran/Champus Coverage **W** = Waived Coverage **X** = COBRA

U = Indian Health Service

I understand and agree that all information listed is true and correctly recorded:

Signature of Authorized Representative
Title
Date

FIELD DEFINITIONS

Employee Last Name: Legal Last, and Jr. or Sr., if applicable.

Employee First Name: Legal First.

Job Title: Job title for each employee.

State of Residence: State in which the employee resides.

Employee Birthdate: Include month, day, and year in the following format: MM/DD/YYYY.

Hours Worked Per Week: Number of hours an employee works per week on a regular basis. Include for all employees whether or not they are enrolling.

Date of Hire: Complete field in MM/DD/YYYY format.

Legal Spouse Yes/No: Indicate if legally married regardless of whether spouse is enrolling.

Birthdates of Each Dependent: Indicate date of birth for each dependent.

Number of Dependents: Indicate number of dependents, regardless of whether dependents are enrolling (excluding employee and spouse).

Enrollment Code - Employee: Refer to enrollment codes on front of form for definitions. Indicate one enrollment code for every employee, regardless of whether they are enrolling. PLEASE NOTE: Code for "enrolling" must match enrollment application for each employee.

Enrollment Code - Spouse and Dependent: Refer to enrollment codes on front of form for definitions. Indicate one enrollment code for every spouse and/or dependent, regardless of whether they are enrolling. PLEASE NOTE: Code for "enrolling" must match enrollment application for each spouse and/or dependent.

COBRA or Continuation: Mark "Yes" only for employees who are currently enrolled in COBRA or State Continuation.

If Regence Life & Health Sold: Only complete this field if group is purchasing life or disability benefits.

Signature of Authorized Representative: An authorized representative of the group.

We recommend you obtain and retain a signed Declination of Coverage form for all employees not enrolled on your current group coverage.