SHOP Participation Request Form

The purpose of this form is to provide company and health insurance policy information to the Marketplace to determine if the selected plans to be offered by the employer are considered certified plans for the Small Business Health Coverage tax credit. The Marketplace does not determine eligibility for the tax credit.

THIS FORM MUST BE TYPED. HANDWRITTEN FORMS WILL NOT BE ACCEPTED. MISSING INFORMATION OR BLANK FIELDS MAY LEAD TO A DELAY IN PROCESSING.

Requested effective date:			
COMPANY INFORMATION			
Company legal name:	Company DBA name:		
Address:			
City:	State:	ZIP code:	
Mailing address *(if different from above):*			
City:	State:	ZIP code:	
Headquarters location: City:	State:	ZIP code:	
PRIMARY CONTACT/SECONDARY CONTACT			
Primary contact name:	Title:		
Email address:	Phone #:	Fax #:	
Secondary contact name:	Title:		
Email address:	Phone #:	Fax #:	
AGENT INFORMATION			
Name:	Agent Oregon license #:		
Email address:	Phone #:	Fax #:	
COVERAGE AND EMPLOYER CONTRIBUTION AMOUNTS			
Enrolling in: ☐ Medical ☐ Dental **OR** ☐ Both	Number of employees:		

Carrier Name:	Plan Name:	Plan ID Number: (Refer to list of certified plans)	Total Employee Premium*:	Employer Contribution**:

*Please provide full employee only premium amount (before any contributions).
**Employer contribution towards premium can be provided as a percentage or a dollar amount.

Form should be completed by insurance carrier. When completed, e-mail the form to shop.marketplace@odhsoha.oregon.gov.