Bend Chamber of Commerce Association Health Plan

2026 Renewal confirmation form

Please complete the below application and submit to **JBPadmin@johnsonbenefitplanning.com** 20 days prior to the effective date of your policy to avoid disruption of coverage. If the Confirmation Form is not received, your group will be renewed as-of-

Group Name		
Group Number	Effective Date of Renewal	NAICS Code

Renewal options

Please return to Johnson Benefit Planning.

Was this group re-rated? If yes, please provide a copy of both the revised rate page and census used.	☐ Yes ☐ No

☐ **Option 1**	☐ **Option 2**
Renew as offered. All group contact and eligibility information remains unchanged. Please check this box, sign and date page 2.	**Renew, but with the changes noted below.** Please note: any section left blank will remain unchanged. Please check this box, sign and date page 2.

What plan options would you like to be renewed with?

Medical/Rx Plan Option 1
Medical/Rx Plan Option 2
Medical/Rx Plan Option 3
Vision Plan Rider

Groups with 5 or more enrolling subscribers may offer up to two Delta Dental plans in addition to a Willamette Dental plan.
The Delta Dental Super Plan is available only to groups with 5 or more enrolling subscribers.
Orthodontia coverage is available only to groups with 10 or more enrolling subscribers.

Delta Dental Plan Option 1
Delta Dental Plan Option 2
Delta Dental Orthodontia Rider

CDHP Accounts

HSA (with optional integration), HRA, FSA, and POP accounts are available through our partner, BenefitHelp Solutions (BHS). Please review the pricing sheet and select the account(s) you would like to enroll in below. A representative from BHS will then reach out separately to initiate services.

☐ HSA (with optional integration) ☐ HRA ☐ FSA ☐ POP

Eligibility Changes

Would you like to update your probationary period? **If yes, what probationary period do you select?** **If the end of probationary period falls on the first day of the month, when will the new employee be effective?** ☐ Eligible that day ☐ Must wait until the first day of the following month or 91st day; whichever comes first	☐ Yes ☐ No
Minimum hours: How many hours per week must an employee work to be eligible for coverage? _____ *(must be between 17.5 and 40 hours – please note a large employer is advised not to exceed 30 hours)*	
Employer premium contribution: Medical: Employee _____ % Dependent _____ % *The minimum employer premium contribution is 50% toward the employee only premium.*	
Domestic partner coverage: In addition to the same-sex domestic partner coverage, would you like to offer opposite-sex domestic partner coverage?	☐ Yes ☐ No
Do you currently have COBRA Administration offered at no charge from BHS? **If no, do you want to add it at no additional cost?** ☐ No ☐ Yes, please complete and attach the BHS COBRA intake packet	☐ Yes ☐ No

Termination

☐ **Terminate this medical coverage at renewal?** Reason: _____ New carrier(s): _____
☐ **Terminate this dental coverage at renewal?** Reason: _____ New carrier(s) _____

Signature

I understand that retroactive changes to benefits or eligibility are not permitted. I agree to apply eligibility requirements consistently to all eligible employees and dependents and acknowledge that compliance with ACA eligibility requirements and all applicable state and federal regulations is my responsibility.

Authorized Signature for Group X	Date
Authorized Signer's Printed Name	Title
Email Address	Phone Number

Ready to submit?

Email: JBPadmin@JohnsonBenefitPlanning.com