Equivalent Plan Application

Paid Leave Oregon

Introduction:
Equivalent plans are employer-offered paid leave programs. If approved, employers will provide paid leave benefits to their employees through the approved equivalent plan instead of the state offered Paid Leave Oregon program. Equivalent plans can be employer administered or purchased fully-insured insurance policies.

Best practices and tips for equivalent plan submission:

- Familiarize yourself with all program requirements prior to starting an application by reviewing the Equivalent Plan Guidebook at paidleave.oregon.gov
- Allow at least 30 days for a decision. If approved, your equivalent plan will become effective the first day of the next quarter.
- If you have any questions, please contact us at 1-833-854-0166.

Payment Information:

- We only accept checks for paper applications. If you would like to pay by ACH, please fill your Equivalent Plan application online at frances.oregon.gov. Please make checks payable to 'Paid Leave Oregon - Employment Department.' Include 'equivalent plan application' in the memo section of your check.

Fee Information:

- Initial approval of an equivalent plan is $250.

Employers submitting plans for re-approval will be notified if their plan has substantive or non-substantive changes and assessed the associated reapproval fee:

- Re-approval of an equivalent plan with substantive changes is $250.
- Re-approval of an equivalent plan with non-substantive or no changes is $150.

Instructions:

- **Fields marked with * are required**
- Please ensure responses are legible
- We will notify you by mail after your application is reviewed
- Complete this form in black or blue ink
- Mail the completed form and required documents to the address on Page 4

You must complete an application for each Business Identification Number (BIN). A completed application requires:

- If you are applying for an employer administered plan, fill out sections A, C, D, E, F and mail a copy of your application, equivalent plan, solvency documents, and check payment.
- If you are applying for a fully-insured plan, fill out sections A, B, C, D, F and mail a copy of your application, equivalent plan or insurance policy, and check payment.
- If you are applying for reapproval of your employer administered plan, fill out sections A, C, D, E, F and mail a copy of your application, equivalent plan, solvency documents, and check payment.
- If you are applying for reapproval of your fully-insured plan, fill out sections A, B, C, D, F and mail a copy of your application, equivalent plan or insurance policy, and check payment.

SECTION A - CONTACT INFORMATION			
Contact information will be used by staff if we have any questions about your equivalent plan application			
*Business Name:		*Federal Employer Identification Number (FEIN): ____ - _____	
*Business Identification Number (BIN): _____ - ____			
*First Name:		*Last Name:	
*Phone Number:		*Email:	
Physical Address			
*Street Line 1:			
Street Line 2:			
Unit Type:	Unit Number:		*City:
*State:		*Zip:	County:
Mailing Address (If different from physical address)			
*Street Line 1:			
Street Line 2:			
Unit Type:	Unit Number:		*City:
*State:		*Zip:	County:

SECTION B - INSURANCE CARRIER CONTACT INFORMATION (IF APPLICABLE)			
*Insurance Carrier Name:			
*Insurance Contact Name:			
*Phone Number:		*Email:	
Physical Address			
*Street Line 1:			
Street Line 2:			
Unit Type:	Unit Number:		*City:
*State:		*Zip:	County:
Mailing Address (If different from physical address)			
*Street Line 1:			
Street Line 2:			
Unit Type:	Unit Number:		*City:
*State:		*Zip:	County:

SECTION C - POLICY / PLAN DETAILS
Please provide the following details regarding your plan. If you would like more information about the differences between a Fully-Insured plan or Employer Administered plan, please see the Equivalent Plans Guidebook.
Plan Type: ❑ Fully-Insured: (Policy / Form ID Number _____) **OR** ❑ Employer Administered
Date Policy Coverage Begins (MM/DD/YYYY):
Date Policy Coverage Ends (MM/DD/YYYY):

SECTION D - QUESTIONNAIRE		
Plan Details		
1.	Do you currently have an approved equivalent plan with the department?	❑ Yes ❑ No
2.	If "yes", have there been any modifications (including changing from employer administered to fully insured) to the plan?	❑ Yes ❑ No ❑ N/A
Minimum Plan Requirements		
3.	Your plan must be made available to all of your Oregon employees (including full-time, part-time, permanent, or temporary) who have been continuously employed with you for 30 days. Your plan must provide coverage immediately for newly hired employees coming from a job with coverage under an approved equivalent plan. Does your plan meet these requirements?	❑ Yes ❑ No
4.	Your plan must provide the following benefit lengths for leave related to family, medical, and safe leave: a minimum of 12 weeks paid leave to your employee during a period of 52 consecutive calendar weeks (or 53 consecutive weeks, when applicable), plus an additional 2 weeks paid leave for pregnancy, child birth, and related conditions. Does your plan meet all of these requirements?	❑ Yes ❑ No
5.	Your plan must allow leave that can be taken in either a work week or work day increments. Does your plan meet this requirement?	❑ Yes ❑ No
6.	Your plan must provide employees paid medical leave if they are unable to work due to their own serious health condition. Does your plan meet this requirement?	❑ Yes ❑ No
7.	Your plan must provide employees paid family leave to care for a family member or any individual related by blood or affinity whose close association to a covered individual is the equivalent of a family relationship with a serious health condition. Does your plan meet this requirement?	❑ Yes ❑ No
8.	Your plan must provide employees paid family leave to bond with a child during the first year after the child's birth, foster placement, or adoption. Does your plan meet this requirement?	❑ Yes ❑ No
9.	Your plan must provide employees paid safe leave for leave related to domestic violence, stalking sexual assault, or harassment. Does your plan meet this requirement?	❑ Yes ❑ No
10.	Your plan must pay benefits that are greater than or equal to the state's plan to your eligible employees. Does your plan meet this requirement?	❑ Yes ❑ No
11.	Does the plan make a reasonable effort to issue the first payment of benefits to an employee within two weeks after receiving the claim or the start of leave, whichever is later?	❑ Yes ❑ No
Employee Contributions		
12.	An employer may assume all or a part of the costs related to an approved equivalent plan. Do you intend to withhold contributions from your employees' wages to help fund the plan?	❑ Yes ❑ No
13.	Your plan may not require any employee to contribute more than 60% of the total contribution rate. Does your plan meet this requirement?	❑ Yes ❑ No
14.	Contributions withheld from employees covered by an equivalent plan must be used solely to fund the equivalent plan and are not considered part of an employer's assets for any purpose. Will you meet this requirement?	❑ Yes ❑ No
Job Protections & Health Benefits		
15.	Your plan must provide job protection rights to the employee on leave (if they've been employed for 90 days). Does your plan meet this requirement?	❑ Yes ❑ No

16.	You must provide written notice to employees that includes all of the information detailed in OAR-471-070-2330 and provided in the department's written notice template. Will you meet this requirement?	❑ Yes ❑ No
17.	If you currently provide a contribution toward employees' health benefits, you must continue to provide the same health benefits while the employee is on leave as long as they can maintain their share of the employees' cost of medical premiums. If you currently provide a contribution toward employees' health benefits, does your plan meet this requirement?	❑ Yes ❑ No

SECTION E - SOLVENCY DOCUMENTATION (IF APPLICABLE)

Employers with Employer Administered Plans are required to provide proof of solvency by calculating what their contributions amount would be in the state plan and providing documentation (bank statements, bonds, etc.) to verify Equivalent Plan solvency.

Please attach the appropriate documentation to prove solvency for the total amount calculated above. Documents can include a bond, proof of assets, or irrevocable letter of credit.

SECTION F - CERTIFICATIONS

❑ I certify, by submitting this payment, that the application fee is non-refundable and that if my application is denied, I will have to submit an additional payment for any future equivalent plan application fees.

❑ I certify and agree to use employee contributions solely for the purpose of this plan's administration.

❑ I have read and acknowledge the laws set forth in ORS chapter 657B and will follow all current and future requirements in statute, administrative rule, and agency policy for employers offering approved equivalent plans.

❑ I understand the law provides penalties for employers who make false statements or fail to report material facts regarding employee's claims for benefits under this chapter.

❑ **I declare under penalty of perjury that the foregoing is true and correct.**

Executed this _____day of _____ (month), _____ (year) at _____ (city), _____ (state).

Name (Printed):	Title:
Signature:	

CONFIRMATION

Please allow at least 30 days from receipt of your completed application for a decision. If further information is needed, thedepartment will notify the contact person provided.

Please return this form and the required attachments to:

Oregon Employment Department
Paid Leave Oregon Equivalent Plan Application
875 Union St NE
Salem, OR 97311

NEED HELP?

The Oregon Employment Department (OED) is an equal opportunity agency. Everyone has a right to use OED programs and services. OED provides free help. Some examples are sign language and spoken language interpreters, written materials in other languages, braille, large print, audio and other formats. If you need help, please call 833-854-0166 (toll free). TTY users call 711. You can also ask for help at paidleave@oregon.gov.