

REQUEST FOR IDAHO GROUP INSURANCE



Boise (208) 342-3709 or (888) 492-2875
Eugene (541) 686-1242 or (800) 624-6052
Bend (541) 330-8896 or (888) 877-7996
Medford (541) 858-0381 or (800) 899-5866
Portland (503) 699-6561 or (866) 540-1191
Web www.pacificsource.com

EMPLOYER INFORMATION

Legal Name of Employer: _____
Name Doing Business As (DBA), if different than above: _____
Business Street Address: _____
City: _____ Zip Code: _____ County: _____
Billing Address (if different than above): _____
City: _____ State: _____ Zip Code: _____
Phone No.: _____ Fax No.: _____
Name of Contact Person: _____ E-Mail Address: _____
Name(s) of All Owners and Partners: _____
Federal I.D. Number: _____ Name of State Your Company is Headquartered: _____
Business Inception Date: _____ SIC or NAICS Code: _____
Nature of Business (*description of work involved*): _____
Form of Organization (check all that apply): Sole Proprietorship Partnership Government Union Church
 Association MEWA Trust C-Corp Subchapter S-Corp Limited Liability Company Non-Profit

AFFILIATES

Is your company affiliated with any other company? Yes No
Will they also be insured with PacificSource? Yes No If yes, complete and attach the Common Ownership Form
Name of Affiliate(s): _____ Number of Employees: _____
Address of Affiliate(s): _____

HSA, HRA, FSA, COBRA ADMINISTRATION, OR EAP

Check any accounts that your group has: HSA HRA FSA COBRA Admin EAP (multiple boxes can be checked)
Account Administrator(s): Manley Services HSA Bank Umpqua Bank Other: _____
If HSA Bank, do you want one combined bill for HSA contributions and insurance premium? Yes No

GROUP DOCUMENTS

Billing, if multiple locations/classifications: Combined bill Separate bills mailed to: __main group __each location
Handbooks: Hardcopies Electronic copies Send to: Group directly Agent to deliver Client Rep to deliver
Language: Do you need Spanish plan materials? Yes No Other language needs: _____

POLICY EFFECTIVE DATE

The requested effective date for the policy is _____, 20____ (must be 1st or 15th of month)

REQUIREMENTS

- Request for Group Insurance and enrollment materials must be submitted by the 20th of month prior to the policy effective date.
- Common Ownership Form, if your company is affiliated with another company that will be insured by PacificSource.
- FlexPerks Account Set-up Worksheet if applicable for HSA, HRA, and/or FSA plans.
- Check for estimated first month's premium on all requested lines of coverage. Amount: \$ _____
Acceptance of premium does not imply coverage. If coverage does not go into effect, the deposit will be refunded.

EMPLOYER CONTRIBUTION TOWARDS PREMIUM

Minimum Contribution Requirement: 75% employee / 0% dependent (or 50% employee / 50% dependent for groups of 50+)

Medical: Employee _____ % Dependent _____ % **Dental:** Employee _____ % Dependent _____ %

**If employer contribution differs by job classification, please list all contribution variations (attach page if needed).*

PROBATIONARY PERIOD AND PEOPLE TO BE INSURED

Attached all completed enrollment applications. Applications must be submitted for all individuals to be insured, including those on COBRA. Individuals currently eligible and for whom applications are not received will be considered late enrollees and will be subject to waiting periods of up to 12 months from the date of later application.

Hourly Requirement: Employees are required to work _____ hours per week to be eligible for coverage.

Small (2 to 50 employees): Must be between 20 and 30 hours per week.

Large (51+ employees): Must be between 20 and 40 hours per week.

Waiting/Probationary Period: Employees are eligible for coverage the 1st of month following _____ days.

All Size Groups: Must be "first of the month" following between date of hire and 365 days.

- 1. _____ Number of all employees (including full-time, part-time, owners, partners, and principals)
- 2. _____ Number of former employees currently on COBRA with your group health plan (must submit applications)

A. TOTAL EMPLOYEES - Add nos. 1 and 2 above: _____

- 3. _____ Number of employees who do not qualify due to hourly requirement
- 4. _____ Number of employees who do not qualify due to waiting period requirement (must submit applications if eligible within 3 months of effective date)
- 5. _____ Number of employees waiving coverage due to other coverage (waiver forms must be submitted)
- 6. _____ Number of employees not insured for reasons not stated above (waiver forms must be submitted).
90% of all eligible employees not otherwise covered by other qualifying medical coverage must enroll in this plan.

B. TOTAL EMPLOYEES NOT ENROLLING - Add nos. 3 through 6 above: _____

C. TOTAL EMPLOYEES ENROLLING, including continuation - Subtract B from A above: _____

Employees on COBRA: Applications must be submitted for all employees on COBRA continuation.

NAME	CONTINUATION EFFT DATE	QUALIFYING EVENT
_____	_____	_____
_____	_____	_____

COBRA AND HIPAA QUALIFICATION

Did you employ 20 or more total employees (full-time, part-time, and seasonal) on at least 50% of your business days in the **preceding calendar year**? COBRA requires all employees be counted, including those not participating in plan. Yes No

Is your group a church? Yes No

Is your group a branch of the federal government? Yes No

Did you employ on average at least 2 but not more than 50 total employees (full-time, part-time, and seasonal) during the **preceding calendar year**? Count **all** employees (except proprietors and partners) regardless of number of hours worked. Yes No

Did you employ on average 51 or more total employees (full-time, part-time, and seasonal) during the **preceding calendar year**. Count all employees (except proprietors and partners) regardless of number of hours. Yes No

EXISTING INSURANCE

Replacing existing insurance? Yes No If yes, submit proof of prior coverage for credit toward exclusion periods.

Prior Insurance Company: _____ Prior Group No.: _____

Names of any employees whose last names have changed in the past 12 months: _____

Does this insurance replace existing dental insurance? Yes No Prior Company: _____

MEDICAL PLAN DESIGN(S) REQUESTED

Deductible (select one if deductible plan): Calendar Plan year

Product Line:	Plan Designs:				
<input type="checkbox"/> Preferred CoDeduct	<input type="checkbox"/> 500+20/80%	<input type="checkbox"/> 750+40/80%	<input type="checkbox"/> 1500+30/80%	<input type="checkbox"/> 3000+20/80%	<input type="checkbox"/> 5000+40/80%
	<input type="checkbox"/> 500+20/70%	<input type="checkbox"/> 750+40/70%	<input type="checkbox"/> 1500+30/70%	<input type="checkbox"/> 3000+20/70%	<input type="checkbox"/> 5000+40/70%
	<input type="checkbox"/> 500+30/80%	<input type="checkbox"/> 1000+20/80%	<input type="checkbox"/> 1500+40/80%	<input type="checkbox"/> 3000+30/80%	<input type="checkbox"/> 7500+20/80%
	<input type="checkbox"/> 500+30/70%	<input type="checkbox"/> 1000+20/70%	<input type="checkbox"/> 1500+40/70%	<input type="checkbox"/> 3000+30/70%	<input type="checkbox"/> 7500+20/70%
	<input type="checkbox"/> 500+40/80%	<input type="checkbox"/> 1000+30/80%	<input type="checkbox"/> 2000+20/80%	<input type="checkbox"/> 3000+40/80%	<input type="checkbox"/> 7500+30/80%
	<input type="checkbox"/> 500+40/70%	<input type="checkbox"/> 1000+30/70%	<input type="checkbox"/> 2000+20/70%	<input type="checkbox"/> 3000+40/70%	<input type="checkbox"/> 7500+30/70%
	<input type="checkbox"/> 750+20/80%	<input type="checkbox"/> 1000+40/80%	<input type="checkbox"/> 2000+30/80%	<input type="checkbox"/> 5000+20/80%	<input type="checkbox"/> 7500+40/80%
	<input type="checkbox"/> 750+20/70%	<input type="checkbox"/> 1000+40/70%	<input type="checkbox"/> 2000+30/70%	<input type="checkbox"/> 5000+20/70%	<input type="checkbox"/> 7500+40/70%
	<input type="checkbox"/> 750+30/80%	<input type="checkbox"/> 1500+20/80%	<input type="checkbox"/> 2000+40/80%	<input type="checkbox"/> 5000+30/80%	
	<input type="checkbox"/> 750+30/70%	<input type="checkbox"/> 1500+20/70%	<input type="checkbox"/> 2000+40/70%	<input type="checkbox"/> 5000+30/70%	
<input type="checkbox"/> Preferred Deductible and Percentage	<input type="checkbox"/> 80+500	<input type="checkbox"/> 80+2000	<input type="checkbox"/> 70+500	<input type="checkbox"/> 70+2000	<input type="checkbox"/> 50+1000
	<input type="checkbox"/> 80+750	<input type="checkbox"/> 80+3000	<input type="checkbox"/> 70+750	<input type="checkbox"/> 70+3000	<input type="checkbox"/> 50+2000
	<input type="checkbox"/> 80+1000	<input type="checkbox"/> 80+5000	<input type="checkbox"/> 70+1000	<input type="checkbox"/> 70+5000	<input type="checkbox"/> 50/3500
	<input type="checkbox"/> 80+1500	<input type="checkbox"/> 80+7500	<input type="checkbox"/> 70+1500	<input type="checkbox"/> 70+7500	
<input type="checkbox"/> Preferred FlexPerks	<input type="checkbox"/> FP Low Indexed	<input type="checkbox"/> FP80+1500	<input type="checkbox"/> FP80+2000	<input type="checkbox"/> FP High Indexed	<input type="checkbox"/> FP5000
	<input type="checkbox"/> FP80+Low+Rx	<input type="checkbox"/> FP80+1500+Rx	<input type="checkbox"/> FP80+2000+Rx	<input type="checkbox"/> FP80+High+Rx	<input type="checkbox"/> FP5000+Rx
<input type="checkbox"/> Mandated Plans	<input type="checkbox"/> Basic	<input type="checkbox"/> Catastrophic	<input type="checkbox"/> Standard		

OTHER PLAN DESIGN(S) REQUESTED

Product Line:	Plan Designs:			
<input type="checkbox"/> Medical Riders	<input type="checkbox"/> Additional Accident	<input type="checkbox"/> Maternity	<input type="checkbox"/> Elective Abortion	
<input type="checkbox"/> Vision	<input type="checkbox"/> Vision Plus	<input type="checkbox"/> Vision 10/100	<input type="checkbox"/> Vision 10/200	
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Tiered 10/20/40	<input type="checkbox"/> Tiered 15/30/50	<input type="checkbox"/> 15/20%/50%	
<input type="checkbox"/> Dental (available to groups of 2+ w/medical; 10+ dental only)	<input type="checkbox"/> Prev 25/1000	<input type="checkbox"/> Prev 50/1000	<input type="checkbox"/> Comp 25/1000	<input type="checkbox"/> Comp 50/1000
	<input type="checkbox"/> Prev 25/1500	<input type="checkbox"/> Prev 50/1500	<input type="checkbox"/> Comp 25/1500	<input type="checkbox"/> Comp 50/1500
<input type="checkbox"/> Orthodontia	<i>Available to groups with 26 or more employees only</i>			
<input type="checkbox"/> Manley Services TPA	<input type="checkbox"/> FSA Section 125	<input type="checkbox"/> HRA Arrangement	<input type="checkbox"/> COBRA Admin (available to groups of 20+ only)	
<input type="checkbox"/> Other/Variations (list details)				

UNDERWRITING INFORMATION

Do you have union negotiated benefits? Yes No If yes, next scheduled negotiation date: _____

Will this coverage be offered to employees as the sole health insurance option? Yes No

Is any employee or dependent or COBRA-eligible person now pregnant or have current health problems? Yes No

If yes, explain: _____

Describe large or unusual claims: _____

Are any of your employees and/or dependents unable to perform the usual, ordinary duties of his/her occupation or normal activities due to a medical or mental condition? Yes No

Do you have employees who, by court order (QMCSO), must provide medical insurance for a dependent? Yes No

AGENT INFORMATION

Agent: _____ Agency: _____ Agent No.: _____

E-Mail: _____ Phone No.: _____ Fax No.: _____

PLEASE READ CAREFULLY

This is a request for group insurance, not a policy. Under no circumstances will coverage be in force until the policy is issued by PacificSource and accepted by the employer. Once a policy is issued, the terms of the policy shall control in all cases. I affirm that the answers on this application are correct and understand that benefits and eligibility cannot be changed retroactively or improved prior to renewal. I also understand that if this application is not received by PacificSource at least 10 days prior to the effective date, the group is subject to delays.

Employer Signature

Date

Agent Signature

Date

For PacificSource Use Only

MARKETING REPRESENTATIVE REVIEW

Endorsements/Variations/Notes: _____

Mrkt Rep Signature: _____ Date: _____ Approved: _____ Date: _____

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