

**RENEWAL
CONFIRMATION
Idaho**



Important Deadline!
Complete and submit form by the last day of the month prior to your renewal month even if no changes.

EMPLOYER INFORMATION

Group Name: _____ **Group No:** _____ **Renewal Date:** _____

Group Contact Name: _____ **E-mail Address:** _____

Billing Contact Name: _____ **E-mail Address:** _____

Eligibility Information:

• Name of Class _____ Hours _____ (30 hours unless otherwise approved) Probation _____ (1-365 Days)

• Name of Class _____ Hours _____ (30 hours unless otherwise approved) Probation _____ (1-365 Days)

*If the last day of the probation period falls on the first day of the month, will the new employee be eligible for coverage that day or have to wait until the first day of the following month? Eligible that day Must wait (If not answered, default is "must wait".)

Employer Contribution: Toward **Employee** premium: Medical: _____ % Dental: _____ %

Toward **Dependent** premium: Medical: _____ % Dental: _____ %

Domestic Partner: None Same Gender Only Affidavit Any Gender Affidavit (same or opposite gender)

HANDBOOK DISTRIBUTION

Distribution: An electronic copy of your member handbook will be e-mailed to you after it is processed. This searchable format can be saved to your intranet or internal computer system for employee access. A single printed office copy will be mailed or delivered to you.

InTouch Web Portal: Group Administrators and their covered members can also log into InTouch at PacificSource.com to access this quick, easy, searchable handbook and other helpful information online 24/7 from anywhere in the world.

Language: Do you need Spanish benefit summaries? Yes No Other language needs: _____

FEDERAL HEALTHCARE REFORM

Grandfathered Status – PacificSource will renew all small employer groups on non-grandfathered plans. If grandfathered, all provisions included with your renewal apply, unless they would eliminate grandfathered status. Large groups may elect to remain grandfathered if they prefer.

1. If large, what is your health plan? Non-grandfathered Grandfathered

2. If grandfathered, are you accepting the preventive care changes outlined in PPACA? Yes No

BENEFIT INFORMATION

Renew our benefits as outlined in the renewal notice from PacificSource. No other benefit changes.

Renew our benefits with the following changes (list plan name if check "yes").

Preferred Medical: Yes No Plan name(s): _____
Dual Choice: Yes No If yes, selection forms required.

Preferred Options: Additional Accident \$500 Elective Abortion

SmartHealth Medical: Yes No Plan name(s): _____
Dual Choice: Yes No If yes, selection forms required.

SmartHealth Options: Alternative Care \$300 Elective Abortion Mental Health (mental health required if 2-50 employees; option if 51+)

Pharmacy Plan: Yes No Plan name: _____

Vision Plan: Yes No Plan name: _____

Dental Plan: Yes No Plan name: _____
Product: Advantage Advantage Premier Preventive Comprehensive

Orthodontia \$1000: Yes No Orthodontia is only available to groups with 26 or more employees enrolled on dental.

Terminate the following coverage at renewal: Medical Dental Both Medical and Dental

Reason: _____ Name of New Carrier: _____

I acknowledge that retroactive changes to benefits or eligibility are not allowed. I may elect to reduce benefits or eligibility off-renewal, but can't elect to improve them off-renewal except as required by state or federal regulations.

Signed by: _____ **Title:** _____ **Date:** _____

Fax completed form to: 208.344.4262