

**RENEWAL
CONFIRMATION
Oregon**



Important Deadline!
Complete and submit form to PacificSource by the 15th of the month prior to your renewal date 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: Renew as is Change to _____ hours per week **AND** 1st of month following _____ days
Employer Contribution: Employee: Renew as is Change to: Medical: _____ % Dental: _____ %
Dependent: Renew as is Change to: Medical: _____ % Dental: _____ %
Does Your Group Have an HRA or HSA Account?: Yes No - If yes, what does employer contribute to account? _____
Domestic Partner: Registered Only Registered or Same Gender Affidavit Registered or Any Gender Affidavit

FEDERAL HEALTHCARE REFORM

Nondiscrimination Rules – Insured health groups are required to satisfy nondiscrimination rules. The rules prohibit discrimination with regard to eligibility and health benefits that favor highly compensated individuals. Providing different benefits to or excluding eligibility to some categories of employees on the basis of age, years of service, or compensation is not permissible. The DOL has suggested violators could face fines of up to \$100 a day for each employee discriminated against. In December 2010, the IRS announced a delay in enforcement of this provision until regulations are issued. It is anticipated the regulations will not be adopted until after 2011.

We recommend that you either offer coverage to all employees that meet your plan's hourly requirement and probationary waiting period **or** conduct nondiscrimination testing according to provisions of IRS Code 105(5) to confirm your plan complies with the provisions of PHSA section 2716 as amended by PPPACA section 1001(5). Contact your attorney or CPA for assistance if needed.

Grandfathered Status – PacificSource will renew all small employer groups as non-grandfathered. If grandfathered, all provisions in the Notice of Change apply unless they would eliminate grandfathered status. Large groups may elect to remain grandfathered.

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

MEDICAL BENEFIT INFORMATION

Renew our medical benefits as outlined in the renewal notice from PacificSource which includes changes or clarification on power assisted wheelchairs, sleep apnea devices, inpatient rehabilitation, emergencies outside the USA, and open enrollment. No other benefit changes.

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

Medical Plan: Yes No Plan name: _____
Product Line: Preferred CoDeduct Value Prime Choice
Dual Choice: Yes No (no pairing CoDeduct & CoDeduct Value)
Right Fit: Yes No (attach Right Fit Addendum form)

Alt Care/Chiro: Yes No Plan name: _____

Additional Accident: Yes No *Additional accident only available on a plan with a deductible.*

Variations (large): Yes No List: _____

Pharmacy Plan: Yes No Plan name: _____

Vision Plan: Yes No Plan name: _____

DENTAL BENEFIT INFORMATION

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

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

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

Variations (large): Yes No List: _____

Orthodontia: Yes No *Orthodontia only available to groups with 26 or more enrolled employees.*

RATES

Final renewal rates are: Attached Listed Below

	Employee only	Employee + Spouse	Employee + Family	Employee + Children
Medical:				
Pharmacy:				
Vision:				
Alt Care/Chiro:				
_____:				
Total:				

	Employee only	Employee + Spouse	Employee + Family	Employee + Children
Dental:				
Ortho:				
Total:				

DOCUMENT DISTRIBUTION

Book Electronic copy: An electronic copy of your member handbook and contract **will be e-mailed to you** once your group has been processed. This searchable format can be saved to your intranet or internal computer system for employee access.

Book on 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.

Book Hardcopy: In addition to the electronic copy, a single printed office reference copy will be provided to the employer.

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

TERMINATION

Terminate the following coverage at renewal: Medical Dental Vision All Lines of Coverage

Reason: _____ Name of New Carrier: _____

SIGNATURES

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: _____

Mail: PO Box 7068, Eugene OR 97401-0068 Fax: 541.225.3645

Email address is based on your location:

Portlandchanges@pacificsource.com
 Eugenechanges@pacificsource.com
 BendMedfordchanges@pacificsource.com

INTERNAL USE ONLY

Notes: _____

