

**IDAHO 100+ GROUP  
ENROLLMENT  
APPLICATION**



408 E Parkcenter Blvd, Suite 100  
Boise, Idaho 83706  
208.342.3709 or 888.492.2875  
Membership Fax 208.433.4600  
Marketing Fax 208.344.4262  
Pacifsource.com

**Please write legibly in black or blue ink. Complete all applicable sections.**

|                  |              |                            |                      |
|------------------|--------------|----------------------------|----------------------|
| Group Policy No. | Subgroup No. | Class No / Classification. | Name of Medical Plan |
|------------------|--------------|----------------------------|----------------------|

**Section 1 – Employer Information**

|  |   |
|--|---|
| Employer/Group Name  | Effective Date<br>month_____day_____year_____ |
| Date of Full Time Hire (required)<br>month_____day_____year_____                         | Number of Hours Work Per Week                 |
| Employment Status<br><input type="checkbox"/> Active <input type="checkbox"/> Other_____ |   |

**Section 2 – Employee Information**

|  |   |  |
|--|---|--|
| Employee Last Name                           | First Name  | M.I.   |
| Mailing Address                              |   |  |
| City   | State   | Zip code   |
| Home Phone No.                               | E-Mail Address  | Job Title  |
| Date of Birth<br>month_____day_____year_____ | Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status<br><input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other_____ |

**Type:**  New Applicant–Employee  Add dependents  COBRA–qualifying event\_\_\_\_\_

**Due To:**  New Hire  Marriage  Birth  Adoption\*  Court Order\*  Involuntary loss of other coverage\*

**Date Qualifying Event Occurred:** month\_\_\_\_\_day\_\_\_\_\_year\_\_\_\_\_ **\*Attach proof of qualifying event**

**Section 3 – Employee and Family Members You Wish to Enroll**

**\*If this application is for dental coverage only, the policy will provide dental benefits only.**

**\*\*Race/Ethnicity** (choose the code each family member would most closely identify with) : **A**-American Indian/Alaska Native, **B**-Asian, **C**-Black/African American, **D**-Hispanic/Latino, **E**-Native Hawaiian/Other Pacific Islander, **F**-White/Caucasian

| Name            | Gender | Birth Date | Social Security Number<br><i>(Required–refer to disclosure)</i> | *Coverage   | **Race /<br>Ethnicity Code |
|-----------------|--------|------------|---|---|----------------------------|
| Employee        |        |            |   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental |                            |
| Spouse          |        |            |   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental |                            |
| Dependent Child |        |            |   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental |                            |
| Dependent Child |        |            |   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental |                            |
| Dependent Child |        |            |   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental |                            |
| Dependent Child |        |            |   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental |                            |
| Dependent Child |        |            |   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental |                            |
| Dependent Child |        |            |   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental |                            |

If you or your spouse are a court-ordered guardian of any dependent listed above, identify and provide proof:  
Name(s):\_\_\_\_\_ Type:  Grandchild  Niece/Nephew  Sibling  Other\_\_\_\_\_

Primary language spoken in household:  English  Español  Other:\_\_\_\_\_

*Para asistirle en español, por favor llame al numero (800) 624-6052, ext. 1009, de Lunes a Viernes, 8:00 a.m. hasta 5:00 p.m.*

**Section 4 – Prior and/or Current Coverage**

**Current or Prior Coverage Information** – Do you or any person listed on this application have or have had health insurance in the last 12 months?  No  Yes If yes, complete the following **and** attach proof with dates of coverage.

| Name | Insurance Carrier                          | Date of coverage | Will Coverage Continue?                                     | Type of Coverage   |
|------|--|------------------|---|--|
|      | Carrier Name:<br>Policy No.:<br>Phone No.: | Begin:<br>End:   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision<br><input type="checkbox"/> Retiree |
|      | Carrier Name:<br>Policy No.:<br>Phone No.: | Begin:<br>End:   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision<br><input type="checkbox"/> Retiree |

**Married** – Is your spouse employed?  No  Yes If yes, self employed?  No  Yes

**Medicare** – If you or any person on this application have Medicare, is coverage?  Part A  Part B  Part D

| Name | Original Effective Date | Medicare HICN | Medicare No. (include alpha suffix) | Reason for Entitlement   |
|------|-------------------------|---------------|-------------------------------------|--|
|      |                         |               |                                     | <input type="checkbox"/> Age <input type="checkbox"/> ESRD<br><input type="checkbox"/> Disability<br><input type="checkbox"/> Dual Entitlement |

**Section 5 – Child Custody Information**

**If you are enrolling children of a previous relationship, you must complete this section.**

| Child's Name | Whose Child   | Joint Custody   | Custodial Parent Name | Custodial Parent Address | Custodial Parent Phone No. | If Court Order, Name Responsible for Insurance |
|--------------|---|---|-----------------------|--------------------------|----------------------------|--|
|              | <input type="checkbox"/> Yours<br><input type="checkbox"/> Spouse | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                       |                          |                            |  |
|              | <input type="checkbox"/> Yours<br><input type="checkbox"/> Spouse | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                       |                          |                            |  |

**Section 6 – Disability**

**If you or any of your dependents are currently disabled, complete the information below.**

|                          |                       |                                    |
|--------------------------|-----------------------|------------------------------------|
| Name of Disabled Person: | Nature of Disability: | Date of Disability (month & year): |
| Physician's Name:        | Physician's Address:  | Physician's Phone Number:          |

**Section 7 – Health Information Acknowledgement and Declaration**

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating health care treatment, payment, or for business operations necessary to administer health care benefits; or as required by law. Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist, or other physical or behavioral healthcare practitioner; a clinic, hospital, long term care, or other medical facility; any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or an insurer or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be used for to obtain information regarding psychotherapy notes. I also understand that this authorization is needed for the purpose of gathering information to make eligibility or underwriting and risk rating determinations.

As proof of status of employment, I authorize my employer to release to PacificSource appropriate documents, including but not limited to W-2 Wage and Tax Statements and other wage and tax summaries or forms.

Unless revoked earlier, this authorization will be valid for sixty (60) days after the date it is signed. I understand that I can revoke this authorization at any time by giving written notices to PacificSource. I understand that this application will become part of the contract between PacificSource and my employer. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may not be protected by federal rules governing privacy and confidentiality.

I have reviewed all answers and, regardless of whether a producer or other person has completed the answers for me, I affirm that the answers on this application are true and complete. PacificSource may terminate or rescind an employer's group coverage for any revocation or misrepresentation or omission of fact that would have been material in acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date

### Social Security Numbers – Guidelines for Section 3

A Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers to report information that the Secretary of the Department of Health and Human Services for purposes of coordination of benefits. To coordinate Medicare payments with other insurance benefits properly, Medicare relies on the collection of both the Social Security Number (or Medicare Health Insurance Claim Numbers) and the Employer Identification Number. Please provide Social Security Numbers for each family member listed.

### Pre-Existing Condition Exclusion Period – Guidelines for Section 4

**What is a pre-existing condition?** A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended by or received from a licensed provider during the six months preceding the effective date of coverage. The pre-existing conditions exclusion period does not apply to: Newborn babies; Newly adopted children; Pregnancy; Genetic information without a diagnosis of a condition related to such information; Employees who re-enroll after a layoff if they returned to work within six months, to the extent the exclusion period was satisfied before the layoff (exclusion period does apply to their family members, however); or Employees who re-enroll after leave under the Family Medical Leave Act, and their previously enrolled dependents, to the extent the exclusion period was satisfied before the leave.

**How long is coverage for pre-existing conditions excluded?** The plan excludes coverage for pre-existing conditions for twelve months. The twelve-month exclusion period begins on your effective date of coverage, and do not apply to members under age 19.

**If I had prior health coverage, will my pre-existing condition exclusion period be shortened or eliminated?** You can receive credit if you had qualifying health coverage before enrolling in this plan and there was no more than a 63-day gap between your last day of coverage under the prior plan and your first day of coverage (or the first day of your employer's eligibility waiting/probationary period) under this plan. Your prior coverage must have been qualifying existing coverage. Dependents meeting these qualifications will qualify for credit.

**It is your responsibility to show us you had creditable coverage in writing.** If you qualify for credit, we will count every day of coverage under your prior plan toward this plan's exclusion period for pre-existing conditions.

**How can I prove my prior creditable coverage?** You can show evidence by sending us a Certificate of Creditable Coverage from your previous health plan. All health plans, insurance companies, and HMOs should provide these certificates on request, and most issue these automatically when coverage ends. The certificate shows how long you were covered under your previous plan and when coverage ended.

If you do not have a certificate of prior coverage, contact your prior insurance company or plan sponsor (such as your former employer, if a group health plan). If you are unable to obtain a certificate, contact the PacificSource Membership Services Department to assist you.

**Example of how your plan's pre-existing exclusion period rules work.** Mike worked at Oldco, and was covered under Oldco's group health plan for five months. He did not have any health coverage before his Oldco group plan. Mike quit his job at Oldco and did not elect any continuation coverage. Exactly 60 days after quitting, Mike was hired full time at Newco. Newco has a PacificSource group health plan. Mike enrolled in Newco's group plan as soon as he satisfied Newco's eligibility waiting/probationary period.

Mike will receive five months of prior coverage credit for the Oldco coverage because the gap was less than 63 days. His pre-existing conditions exclusion period is reduced to seven months, which begins on his enrollment date (after he satisfies Newco's eligibility waiting/probationary period). Mike's pre-existing conditions look back period is the six months ending on his hire date.

### Special Enrollment Rights – Employee and Eligible Family Members

This group health plan offered by your employer contains provisions that, in certain situations, may allow you or your eligible family members to enroll in the plan later if you decline enrollment when first eligible. If you or your family members decline coverage, you and your family members may enroll in the plan later if you qualify under Rule #1 or #2 below and a **"Waiver of Coverage" form was submitted to PacificSource** during your initial enrollment period or at the time you disenrolled in the group plan.

**Rule #1** - If you declined enrollment because you had other qualifying health insurance coverage, you may enroll in this plan later if the other coverage ends involuntarily. This also applies to dependents that involuntarily lose other coverage. To enroll, request enrollment and pay required premium within 31 days of losing other coverage. Coverage begins on the first day of the month after other coverage ends.

*"Involuntarily" means coverage ended because COBRA was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, other insurance was discontinued or the maximum lifetime benefit of other plan was exhausted, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation.*

**Rule #2** – If you acquire new dependents due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your new dependents if you request enrollment within 60 days of the marriage, adoption, birth, or placement for adoption.

**Dental Coverage** – Dental and medical late enrollment provisions are different. An employee or dependent that did not enroll within the initial enrollment period may enroll later on the policy's anniversary date. An employee or dependent that enrolled and later discontinued coverage may re-enroll on the anniversary date of the policy following a 24-month waiting period from date coverage was discontinued.