

**IDAHO  
GROUP MASTER  
APPLICATION**



408 E Parkcenter Blvd, Ste 100  
Boise ID 83706  
**Phone** 208.342.3709 or 888.492.2875  
**Fax** 208.344.4262  
PacificSource.com

Effective Date: \_\_\_\_\_ 20\_\_\_\_ (Must be received by PacificSource by 5<sup>th</sup> business day of effective month.)

Legal Name of Group: \_\_\_\_\_

DBA Name (will appear on bills/ID cards) (35 character limit): \_\_\_\_\_

Business Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Billing Address (if different than above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone No.: (\_\_\_\_) \_\_\_\_\_ Fax No.: (\_\_\_\_) \_\_\_\_\_

Group Admin—First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Billing Contact—First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Name(s) of All Owners and Partners: \_\_\_\_\_

Federal I.D. Number: \_\_\_\_\_ Name of State Company is Headquartered: \_\_\_\_\_

Business Inception Date or Years in Business: \_\_\_\_\_ SIC 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

Name of Affiliate(s): \_\_\_\_\_ Number of Employees: \_\_\_\_\_

Address of Affiliate(s): \_\_\_\_\_  Attach the Common Ownership Form

**HSA, HRA, FSA, COBRA ADMINISTRATION, OR EAP**

Check any accounts your group has and provide details:  HSA  HRA  FSA  COBRA Admin  EAP

Company Name \_\_\_\_\_ Contact \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Employer Contribution to HRA or HSA \_\_\_\_\_ If HSA Bank, do you want an integrated bill?  Yes  No

**DOCUMENT DISTRIBUTION**

**Billing:** If multiple locations/classifications:  Combined bill  Separate bills mailed to: \_\_main group \_\_each location

**ID Cards:** Mailed directly to the home of each employee and dependent age 16 or older (or custodial parent's home, if applicable).

**Book Electronic Copy:** An electronic copy of your member handbook and contract **will be e-mailed to you** after your group has been processed. This searchable electronic 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: \_\_\_\_\_

**REQUIREMENTS – MUST BE SUBMITTED PRIOR TO POLICY EFFECTIVE DATE**

Group Master Application  Signed copy of quoted rates  Enrollment Applications and/or Waiver Forms

Electronic Funds Transfer form, if you want PacificSource to withdraw your monthly premium from your bank account

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 Employer Contribution Requirement:** Medical 50% employee / dependents

**Medical\*:** Employee \_\_\_\_\_ % Dependent \_\_\_\_\_ % **Dental\*:** Employee \_\_\_\_\_ % Dependent \_\_\_\_\_ %

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

**ELIGIBILITY INFORMATION**

**Completed member enrollment applications must be submitted for all individuals to be insured, including those on COBRA and waivers.** Individuals currently eligible and for whom applications are not received will be considered late enrollees.

**HOURLY AND WAITING/PROBATIONARY PERIOD:** Employer determines hours and days worked for eligibility, subject to the following:

- *Small Employer (2 to 50 employees): Must be "first of the month" following between 1 and 365 days and 30 hours.*
- *Large Employer (51+ employees): Must be "first of the month" following between 1 and 365 days and 20 and 40 hours.*

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 Public Health Service Act section 2716 as amended by Patient Protection and Affordable Care Act section 1001(5). The Department of Labor has suggested violators can face fines of up to \$100 a day per employee discriminated against. Contact your attorney or CPA for assistance.

- Name of Class \_\_\_\_\_ Hours \_\_\_\_\_ Days\* \_\_\_\_\_
- Name of Class \_\_\_\_\_ Hours \_\_\_\_\_ Days\* \_\_\_\_\_

• \*If the last day of the probationary 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".)

1. \_\_\_\_\_ Number of **all** employees (include full-time, part-time, owner, partner, principal, probationary, & waiver; exclude COBRA)
2. \_\_\_\_\_ Number of former employees currently on COBRA with your group health plan (must submit applications)

**A. TOTAL EMPLOYEES** – Add numbers 2 and 3 above: \_\_\_\_\_

3. \_\_\_\_\_ Number of employees who do not qualify due to hourly or waiting period requirement
4. \_\_\_\_\_ Number of employees waiving coverage due to other coverage (waiver forms or applications must be submitted)
5. \_\_\_\_\_ Number of employees not insured for reasons not stated above (requires prior approval from PacificSource)

Please explain reason (e.g., classification not eligible, chose not to participate): \_\_\_\_\_

**B. TOTAL EMPLOYEES NOT ENROLLING** – Add numbers 4 through 6 above: \_\_\_\_\_

**C. TOTAL EMPLOYEES ENROLLING, including COBRA** – Subtract B from A above: \_\_\_\_\_

**D. DOMESTIC PARTNER** – Are domestic partners eligible for coverage? Yes No – If yes: Same Gender Only Any Gender

**E. INITIAL ENROLLMENT** – Will the initial group of employees be required to meet the waiting period? Yes No

**F. SERVICE AREA** – Do all employees reside within the PacificSource service area? Yes No

**G. ACCESS PROGRAM** – Is your group using the Access Program through the State of Idaho Health and Welfare? Yes\* No

*\*If a Notice of Decision Letter has not been received, you must pay the first month's premium at initial enrollment.*

**H. OTHER FUNDING** – Does your company fund the medical benefits under the deductible (buy-down or HRA) ? Yes No

**I. COBRA** – Did you employ 20 or more total employees (full-time, part-time, and seasonal) on at least 50 percent of your business days in the **preceding calendar year**? Yes No

**Employees on COBRA of coverage:** Applications must be submitted for all employees on COBRA.

Name	COBRA Effective Date	Qualifying Event	AEI Eligible*
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

*\*AEI is an "assistance eligible individual" for subsidy for COBRA coverage under the American Recovery and Reinvestment Act*

**EXISTING OR PRIOR INSURANCE – Submit copy of last billing statement showing employees' names.**

What existing group insurance are you replacing? Health/Medical Insurance Dental Insurance

Prior Carrier(s) Replacing: \_\_\_\_\_ Policy No.: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Date Coverage Effective: \_\_\_\_\_ Date Coverage Terminated: \_\_\_\_\_ Is Coverage Still in Force? Yes No

Employees whose last names have changed in the past six months: \_\_\_\_\_

**WORKER'S COMPENSATION**

Name of Insurance Carrier: \_\_\_\_\_ Policy No.: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Please provide information regarding any individuals not covered under your Worker's Compensation policy in the space below:

Name(s)	Title(s)	Reason(s) Not Covered
_____	_____	_____
_____	_____	_____

**DISABILITY INFORMATION**

Are any employees currently absent due to illness or injury, or currently receiving disability benefits? Yes No

Name of Disabled Person	Date of Disability	Cause of Disability	Physician's Name, Address, & Phone No.
_____	_____	_____	_____
_____	_____	_____	_____

**BENEFIT INFORMATION**

**Check "yes" or "no" to indicate coverage selection(s). List plan name for any product checked "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; optional if 51+)*

**Pharmacy Plan:** Yes No Plan name: \_\_\_\_\_

**Vision Plan:** Yes No Plan name: \_\_\_\_\_

**Dental Plan:** Yes No Plan name: \_\_\_\_\_

Dental only group of 2-9 enrolled employees can only select "Advantage".

*Product:* Advantage Advantage Premier Preventive Comprehensive

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

**Manley Services:** FSA Section 125 HRA Arrangement COBRA Admin *(available to groups of 20+ only)*

**Other Benefits / Variations (list):** \_\_\_\_\_

**LARGE EMPLOYER GROUPS OF 51 OR MORE EMPLOYEES**

Will you keep grandfathered status or change to nongrandfathered? Nongrandfathered Grandfathered—answer the following:

- Prior carrier benefits, cost sharing, employer contributions, and annual limits attached (*i.e., prior carrier contract*)? Yes No
- Have you confirmed you meet the requirements of grandfathered status? Yes No
- Are you accepting the change to cover preventive care services at participating providers at 100%? Yes No

**EMPLOYEE CENSUS**

To allow for compliance of IDAPA 18.01.69.046, complete the below census and submit applications or waivers for all eligible employees.

List **all** employees. Include 1099 contractors, officers, owners, and partners. Include full-time, part-time, in a waiting period, waiving coverage, temporary or seasonal, ineligible, or that that have elected or are eligible for COBRA. **Attach additional pages if needed.**

**Status:** E=Eligible, NE=Not eligible due to hours, P=In probationary period, C=COBRA, W=Waiving, T=Termed employment,

**Reason Waiving:** OG=Other group coverage, OI=Other individual coverage, M=Medicare/Medicaid, C=Cost, DW=Does not want coverage, P=Part-time employee, TS=Temporary or seasonal

Employee Name	Position	Hours Per Week	Hire Date	Already Enrolled?	Status (see above)	Reason Waiving (see above)
1						
2						
3						
4						
5						
6						
7						
8						
9						

Employee Name	Position	Hours Per Week	Hire Date	Already Enrolled?	Status (see above)	Reason Waiving (see above)
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						

Total Number Employees Listed: \_\_\_\_\_ **Check One:**  Above includes all employees  Additional employee census attached

**AGENT INFORMATION**

Agent: \_\_\_\_\_ Agency: \_\_\_\_\_ Agent 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. The terms of the policy shall control in all cases. I affirm that the answers on this application are correct and understand the following:

- I certify the census provided is accurate and complete as of this date and I have the authority to submit this information. I understand this information will be used to underwrite my group, to determine eligibility, and to fulfill the requirements of IDAPA 18.01.69.046.
- An employee that does not enroll in medical during their initial enrollment period must wait until the first of the next renewal period to enroll. That waiting period does not apply if the employee qualifies for special enrollment.
- An employee that does not enroll in dental during their initial enrollment period and does not qualify for a special enrollment period must wait until first of the next renewal period to enroll. An employee or dependent that enrolled and later discontinued coverage must wait until the next renewal period following a 24-month waiting period from date coverage was discontinued.
- I acknowledge that when two employees are married to each other and enroll as a family instead of separately, a waiver form or waiver section of the enrollment application must be completed for the spouse (can be signed by either the employee or spouse).
- Acceptance of premium or receipt of ID cards does not imply coverage. If coverage does not go into effect, deposit is refunded.
- I understand that eligibility standards (e.g., probationary period, minimum hours, etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents (even owners).
- I agree to make all coverage options available to all eligible employees and dependents that satisfy eligibility requirements.
- I acknowledge benefits may be added or enhanced only at time of initial group application, at contract renewal, when required by law, or when PacificSource makes a carrier-wide decision to do so. I may reduce benefits off-renewal. Retroactive changes are not allowed and will not be effective prior to the first of the month following the date the request is received by PacificSource.

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent Signature

\_\_\_\_\_  
Date