OREGON 100+ EES GROUP MASTER APPLICATION

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
PacificSource.com

Complete this form only if your group has 100 or more covered employees.

EMPLOYER INFORMATION

Effective Date of This Policy: ______________________, 20________ *(Must be received by PacificSource by 20th of prior 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:______________________

Group Admin E-Mail Address:________________________________ *(used for important communications only; not shared)*

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:______________________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

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: ☐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 each covered employee's home (or custodial parent's home 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 ☐Copy of quoted rates

☐Enrollment Applications or electronic file (enrolling employees) ☐Waiver Forms (eligible employees declining coverage)

☐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 Contribution Requirement: *If dual choice base/buy-up, minimum employer contribution is based on the base plan.*

51+ eligible employees: medical 75%/0% or 50%/50%; dental 75%/0% or 50%/50%

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).*

PROBATIONARY PERIOD AND PEOPLE TO BE INSURED

Completed member enrollment applications must be submitted for all individuals to be insured, including those on continuation of coverage 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:

- *Large Employer (51+ employees): Must be "first of the month" following between 1 and 180 days and 17.5 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*______________

Initial Enrollment: Do you wish to waive the waiting period for all employees at initial enrollment? ☐Yes ☐No

*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 continuation)*
2. _______Number of former employees currently on COBRA continuation with your group health plan *(must submit applications)*

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

Name	Continuation Effective Date	Qualifying Event

DOMESTIC PARTNER: Are non-registered partners eligible? ☐Yes ☐No – *If yes*: ☐Same Gender Only ☐Any Gender

EXISTING OR PRIOR INSURANCE – Submit copy of last 6 month's billing statements showing employees' names.

Replacing existing group health insurance? ☐Yes ☐No Prior Carrier:______________________Policy No.:__________

Date Prior Coverage Effective:__________Date Coverage Terminated:____________Phone No.:______________

Replacing existing group dental insurance? ☐Yes ☐No Prior Carrier:______________________Group No.:__________

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

BENEFIT INFORMATION

Check "yes" or "no" to indicate coverage selection(s). List plan name for any product checked "yes".

Medical Plan: ☐Yes ☐No Plan name(s): ___________________________

Product: ☐Preferred ☐Prime ☐Choice ☐BHP

Plan: ☐CoDeduct ☐CoDeduct Value ☐Deductible ☐Percentage ☐Copay ☐HSA

Type of Deductible: ☐Calendar Year ☐Plan/Contract Year ☐None

Dual Choice: ☐Yes ☐No *(no pairing Preferred CoDeduct & CoDeduct Value)*

Additional Accident: ☐Yes ☐No *Additional Accident is only available as a rider on a plan with a deductible.*

Alternative Care/Chiro: ☐Yes ☐No Plan name: ___________________________

Benefit Maximum: ☐$500 ☐$1,000 ☐$1,500 ☐$2,000 ☐$2,500

Pharmacy Plan: ☐Yes ☐No Plan name: ___________________________

Vision Plan: ☐Yes ☐No Plan name: ☐Vision 10/150 ☐Vision 10/300 ☐Vision Plus ☐Vision Exam Only

Dental Plan: ☐Yes ☐No Plan name: ___________________________

Product: ☐Advantage ☐Advantage Premier ☐Preventive ☐Comprehensive

Type of Deductible: If medical is also with PacificSource, same style as medical. Otherwise:

- *Advantage/Advantage Premier have plan/contract year deductibles.*
- *Preventive/Comprehensive have calendar year deductibles.*

Orthodontia: ☐Yes ☐No Plan name: ___________________________

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

Other Benefits / Variations (list): ___________________________

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FEDERAL HEALTHCARE REFORM (STATUS)

What is your health plan? ☐Nongrandfathered ☐Grandfathered–answer the following:

- You must provide PacificSource documentation of prior carrier benefits, cost sharing, employer contributions, and annual limits prior to enrollment *(i.e., copy of your prior carrier contract)*. Documentation attached? ☐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

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 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 the following:

- I must submit this completed application prior to the requested effective date, or the policy effective date may be delayed.
- 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, the oldest employee will always be enrolled as the employee and the youngest as the spouse regardless how the application is completed.
- 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

For PacificSource Use Only

RATES AND ENROLLMENT

Medical Enrollment:	Ee Only	Ee + Spouse	Ee + Family	Ee + Children
Medical:				
Pharmacy:				
Vision:				
Alt Care/Chiro:				
______________:				
Total:				

Dental Enrollment:	Ee Only	Ee + Spouse	Ee + Family	Ee + Children
Dental:				
Ortho:				
Total:				

Other Eligibility:

Number of qualified waivers:________________

Number of unqualified waivers:______________

Number of COBRA subscribers:_____________

VARIATIONS OR ENDORSEMENTS

Financial: ☐Fully Insured ☐Single Source ASO ☐Options ASO ☐Retrospective ☐Minimum Funding

Bill: ☐4-Tier ☐3-Tier ☐2-Tier ☐Composite ☐Other ____

Commission: Medical:____________________ Dental:___________________ Other:__________________________

Benefit Variations: ____

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Eligibility Endorsements: ____

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Notes: ____

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