

**OREGON 2-99 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 99 or fewer 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 Oregon Standardized Group Profile Form (GPF) Copy of quoted rates

Enrollment Applications (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.*

- 2-25 eligible employees: medical 50%/0%; dental 50%/0%
- 26-50 eligible employees: medical 50%/0%; dental 75%/0% or 50%/50%
- 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:

- *Small Employer (2 to 50 employees): Must be "first of the month" following between 1 and 90 days and 17.5 and 40 hours.*
- *Large Employer (51-99): 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* _____

*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 continuation with your group health plan (must submit applications)

A. TOTAL EMPLOYEES - Add numbers 1 and 2 above: _____

3. _____ Number of employees who do not qualify due to hourly requirement
4. _____ Number of employees who do not qualify due to waiting period requirement
5. _____ Number of employees waiving coverage due to other group coverage (waiver forms must be submitted)
6. _____ 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 3 through 6 above: _____

C. TOTAL EMPLOYEES ENROLLING, including continuation - Subtract B from A above: _____

D. CONTINUATION TYPE (State or 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 continuation of coverage: *Applications must be submitted for all employees on continuation.*

Name	Continuation Effective Date	Qualifying Event
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

E. 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)
Right Fit: Yes No (attach Right Fit Addendum indicating plan design options)

Additional Accident: Yes No Additional Accident \$500 is only available as a rider on a plan with a deductible.

Alt Care/Chiro: Yes No Plan name(s): _____
Benefit Maximum: \$500 \$1,000 \$1,500 \$2,000 \$2,500 (large groups only)

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: _____

Standalone Dental groups with 2-9 covered employees are limited to the \$50 Dental Advantage plans with a \$1000 or \$1500 max.

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 \$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): _____

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 will 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 or state continuation subscribers: _____

VARIATIONS OR ENDORSEMENTS FOR LARGE EMPLOYERS

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: _____

Eligibility Endorsements: _____

Notes: _____
