

Bend Chamber of Commerce Association Plan Group Renewal Confirmation Form

Important! Complete and submit this renewal form to PacificSource by the 10th of the month prior to your renewal date even if there are no changes. Renewal confirmations are processed in the order they are received.

Group name _____ Group no. _____ Renewal date _____

Renewal Options

Option 1

Renew on current plan design, ACCEPT all changes outlined in the notice of change letter or as required by regulations. All group contact and eligibility information remains unchanged, except as required by regulations. Please check this box, sign and date page 2, and email this request to your sales team at one of the following: BendSales@pacificsource.com or MedfordSales@pacificsource.com.

Option 2

Make changes as noted below, ACCEPT all changes outlined in the notice of change letter or as required by regulations. Please note any section left blank will remain unchanged. Please email this request to your sales team at one of the following: BendSales@pacificsource.com or MedfordSales@pacificsource.com.

Eligibility Changes

Probationary period (select one): First of the month following:

Date of hire 30 days 60 days
90 calendar days (effective 91st calendar day; first month premium prorated)

Minimum hours: How many hours per week must an employee work to be eligible for coverage?

___ hours per week (Must be between 17.5 - 30 hours)

Employer premium contribution

Medical: Employee ___% Dependent ___% Dental: Employee ___% Dependent ___%

Does your group have an HRA or HSA?

No Yes; if yes, what does the employer contribute to account? _____

Eligible members: This plan covers

Employee + spouse/domestic partner + children
Employee + children only (option only for large group)

Domestic Partner coverage

In addition to the same-sex domestic partner coverage, would you like to offer opposite-sex domestic partner coverage? No Yes

Benefit Changes

Renew on current medical plan design(s) and ACCEPT all changes outlined in the notice of change letter or as required.

Renew on current dental plan design and ACCEPT all changes outlined in the notice of change letter or as required.

Change to the plan(s) below. List the plan name(s) exactly as listed on your renewal notice (i.e., PSN HSA 3000+Rx).

Medical/Rx plan(s) _____

Vision plan _____

Acupuncture/ Chiro _____

Dental plan _____ Orthodontia max \$1,000

Termination

Terminate this coverage at renewal: Medical Dental Other _____ All lines of coverage

Reason _____ New carrier(s) _____

Signature (please read carefully)

- I acknowledge that retroactive changes to benefits or eligibility are not allowed. Any off-renewal change requests will be effective the first of the month following the date that PacificSource receives the written request.
- I understand that eligibility standards must be adhered to for all employees and their eligible dependents. I agree to make all coverage options available to all eligible employees that satisfy the hourly and probationary wait requirements.
- I understand that it is my responsibility to comply with the eligibility provisions of the Affordable Care Act and any related state or federal guidance. Noncompliance may result in the group penalty from federal agencies.

Signature _____ Title _____ Date _____

Email by location to BendSales@pacificsource.com, or MedfordSales@pacificsource.com, or fax to (541) 330-8948

Mail to PacificSource Health Plans ATTN: Sales, 2965 NE Conners ave, Bend, OR 97701

InTouch for Employers: InTouch.pacificsource.com/ITE/Login; Benefit Summaries: PacificSource.com/plan-summaries