PacificSource HEALTH PLANS

Bend Chamber of Commerce Association Plan
Member Group Application

BEND Chamber Association Health Plan

EMPLOYER INFORMATION

Is your group a current member of the Bend Chamber of Commerce in good standing? ☐Yes ☐No

Legal Name of Group	Requested Effective Date
DBA Name (will appear on bills/ID cards; 35 character limit)	SIC or NAICS Code

Physical Address Required (No PO Box)	City	State	Zip Code	County
Mailing Address (if different than Physical Address)	City	State	Zip Code	County

Federal Tax ID No.	Company Headquarters State	Nature of Business (description of work involved)

Trust affiliation:
☐Auto and Motorsports ☐Business and Professional ☐Communications and Utilities
☐Contractors ☐Healthcare ☐Human Services
☐Manufacturing ☐Real Estate ☐Wood Products

Name(s) of All Owners and Partners

GROUP CONTACT

Name for Eligibility & Benefits	Phone No.	Email	Fax No.
Name for Billing	Phone No.	Email	Fax No.

AFFILIATES

Is your company affiliated with any other company? ☐Yes ☐No
Will they be insured with PacificSource? ☐Yes, Common Ownership form is attached. ☐No

Name of Affiliate(s)	Number of Employees

Address of Affiliate(s)

CURRENT INSURANCE

Medical Carrier: _____ Policy #: _____ Term Date:_____

Dental Carrier: _____ Policy #: _____ Term Date:_____
Who was eligible for your prior dental plan? ☐Children only ☐Adults and Children

Existing Workers' Compensation Carrier: _____Policy #_____

ELIGIBILITY

Probationary Waiting Period.

First of the month following your selection: ☐Date of hire ☐30 days ☐60 days
☐90 calendar days; effective on 91st calendar day *(premium prorated first month)*

Status Change–If an employee changes from part-time to full-time or from temporary to permanent, how will you apply probation?

☐Credit time as part-time or temporary toward probationary wait period (not allowed for new hires transferring from a temp agency)

☐Probationary wait period begins when status changes

Initial Enrollment: If the group has no prior coverage, then allow employees to waive probationary period at initial enrollment? ☐Yes ☐No

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

Class_____ Hours per week_____

Class_____ Hours per week_____

EMPLOYER CONTRIBUTION TOWARDS PREMIUM

Medical: Employee_____ Dependent _____

Dental: Employee_____ Dependent _____

BENEFIT INFORMATION

Check to indicate coverage selection(s).

Medical Plan:

☐PSN Balance 1500+35_Rx	☐PSN Balance 1500+35_Rx 10-50-75
☐SmartChoice Balance 1500+35_Rx	☐SmartChoice Balance 1500+35_Rx 10-50-75
☐PSN Balance 2000+35_Rx	☐PSN Balance 2000+35_Rx 10-50-75
☐SmartChoice Balance 2000+35_Rx	☐SmartChoice Balance 2000+35_Rx 10-50-75
☐PSN Balance 3000+35_Rx	☐PSN Balance 3000+35_Rx 10-50-75
☐SmartChoice Balance 3000+35_Rx	☐SmartChoice Balance 3000+35_Rx 10-50-75
☐PSN Balance 5000+35_Rx	☐PSN Balance 5000+35_Rx 10-50-75
☐SmartChoice Balance 5000+35_Rx	☐SmartChoice Balance 5000+35_Rx 10-50-75
☐PSN Value 3000_50+Rx (HSA qualified)	☐PSN Value 6000+Rx (HSA qualified)
☐PSN Chamber Core 5000_50+Rx	☐SmartChoice Chamber Core 5000_50+Rx

Vision Plan:

☐None	☐Vision 10/150

Acupuncture/Chiro:

☐None	☐Acupuncture/Chiro 1000

Dental Plan (Dental-only offered to groups of five or more enrollees):

☐None	☐Plan 2 20/50/50/75 50/1000
☐Plan 1 0/20/20/50 50/1000	☐Plan 3 0/20/20/50 50/1500

Orthodontia (offered to groups of 10 or more enrollees):

☐None	☐50%/$1000 for all enrolled members (12-month waiting period)

HSA, HRA, FSA, COBRA ADMINISTRATION, OR EAP

Check accounts your group has: ☐HSA ☐HRA ☐FSA ☐COBRA Admin ☐EAP

Employer Contribution to HRA or HSA:

Third Party Administrator Name	Address

Phone No.

PEOPLE TO BE INSURED

1. _____ Total Number of employees (full-time, part-time, owner, partner, principal, probationary, & waiver; exclude continuation)

2. _____ Total Number of former employees currently on Continuation or Retiree with your group health plan (submit Application and Waiver of Coverage form)

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

3._____ Total number of employees who do not qualify due to hourly requirement

4._____ Total number of employees who do not qualify due to waiting period requirement

5._____ Total Number of employees waiving coverage due to other qualified coverage* (submit Application and Waiver of Coverage form)
*Qualified Coverage: Employer Plan, Medicare, Medicaid, Tricare, and Indian Health Service

6._____ Total number of employees not insured for reasons not stated above

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:_____

SERVICE AREA: Do all employees reside within the PacificSource service area? ☐Yes ☐No If no, list state(s): _____

ERISA: Is your group comprised of employees of a government entity or church that is not subject to ERISA? ☐Yes ☐No

Employees on COBRA continuation of coverage: Application and Wavier of Coverage form must be submitted for each employees on continuation.

Name(s)	Continuation Effective Date	Qualifying Event
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REQUIREMENTS – MUST BE SUBMITTED PRIOR TO POLICY EFFECTIVE DATE

☐Group Master Application ☐Copy of sold rates ☐Enrollment Application & Waiver Forms
☐Electronic Funds Transfer form, if you want PacificSource to withdraw monthly premium from a bank account
☐Binder Payment (est. first month premium) *Refunded if coverage not effectuated*

Wellness Certificate included? (If applicable) ☐Yes ☐No

SIGNATURE – PLEASE READ CAREFULLY

This is an application for group insurance. 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 policy terms control in all cases.

I affirm that I have read this application in its entirety, and that the information I have provided is complete and correct. I understand that if this application contains any intentional misrepresentation of material fact or fraud, PacificSource Health Plans may modify or cancel the contract, and/or take any other legal action available to it by law. I will promptly inform PacificSource Health Plans in writing if anything happens before coverage takes effect that makes the information I have provided on this application incomplete or incorrect.

Group Representative_____Title _____ Date_____

I, the undersigned agent for this group, affirm that the information provided on this application is complete and correct to the best of my knowledge.

Agent _____ Agent No._____ Date_____