Bend Chamber of Commerce Association Plan

Group Renewal Confirmation Form

PacificSource HEALTH PLANS

Important! Complete and submit this renewal form to Johnson Benefit Planning 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 JBPadmin@johnsonbenefitplanning.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 JBPadmin@johnsonbenefitplanning.com.

Eligibility Changes

Probationary waiting period (Please select one):

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

If the last day of the probationary period falls on first day of the month, when will the new employee be effective?

☐ Eligible that day ☐ Must wait until the first day of the following month or 91st day, whichever comes first

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

____ hours per week (must be between 17.5 and 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 the account? _____

Eligible members: This plan covers:

☐ Employee + spouse/domestic partner + children
☐ Employee + children only

Domestic Partner coverage

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

Do you currently have BCOC/PacificSource Administrators (PSA) Cobra Administration?

☐ No ☐ Yes

If no, do you want to add it at no additional cost? ☐ No ☐ Yes

If yes, please attach the PacificSource Administrators COBRA enrollment paperwork.

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., Voyager HSA 3000+Rx).

Medical/Rx plan(s) _____

_____

_____

_____

_____

_____

Vision plan _____

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 completed form to **JBPadmin@johnsonbenefitplanning.com**