Split Carrier Waiver of Coverage



Groups that split their employees between insurers based on employee classification must complete this form.

EMPLOYER / GROUP INFORMATION					
Employer / Group Name	PacificSource Group No., if			o., if known	
Name of Employee Classification to be Insured by PacificSource		Coverage Being Split			
		☐Medical Only ☐Medical+Dental ☐Dental Only			
Type of Carrier Split					
□Union/Non-union □Bargaining Units □Other					
OTHER INSURER INFORMATION Name of Other Insurance Carrier Other Insurer Group No. Name of Other Employee Classification					
Name of other insurance damer	Other insurer Group No. Traine of Other Employee Glassification				
ENROLLMENT REQUIREMENTS					
Small Employer (50 or fewer employees)					
 Allowed: Splits based on union and non-union employee classifications, as well as splits based on bargaining units. 					
Not Allowed: Splits based on any other type of employee classification, except those stated as allowed above.					
Large Employer (51 or more employees)					
Allowed: Splits based on any employee classifications that the group confirms is in compliance with nondiscrimination provisions.					
Minimum Enrolled: Minimum ten enrolled employees with PacificSource. No minimum if based on union/non-union or bargaining units.					
EMPLOYEE SECTION					
List all employees enrolling with the other insurance carrier listed above. Attach an additional page if needed. Employee Full Name Social Security No. Date of Birth (mm/dd/yr) Gender Hire Date (mm/dd/yr)					
Employee Full Name	Social Security No.	Date of Birth	(mm/aa/yr)	Gender	Hire Date (mm/dd/yr)
IME	 PORTANT – PLEASE REA	D AND SIGN	Ī		
I hereby confirm that the above employees are enrolled with the other carrier listed above due to a bona-fide employee classification.					
I understand that the ACA extends Section 105(h) of the IRS Code to non-grandfathered fully-insured group health plans. Eligibility, benefits, and employer contribution cannot be based on job classification, income, or other factors that could favor highly compensated individuals. Federal penalties of \$100 per day per individual discriminated against may apply for noncompliance. I hereby confirm that my group's benefits, eligibility, and employer contribution are in compliance with Section 105(C) of the IRS Code.					
Authorized Signer	Date	Pleas	se Print Name of Authorized Signer		