Small Group Master Application – Montana

For groups of 1-50 employees

PacificSource HEALTH PLANS

Employer information

Legal name of group _____ Effective date _____

DBA name (appears on bills and ID cards) _____ SIC or NAICS code _____

Physical address required (no PO box) _____

City _____ State _____ Zip _____ County _____

Mailing address (if different than physical address) _____

City _____ State _____ Zip _____ County _____

Federal Tax ID No. _____ Company headquarters state _____ Nature of business _____

Name(s) of all owners and partners _____

Form of organization
(check all that apply)

- ☐ Limited liability company
- ☐ Sole proprietorship
- ☐ Subchapter S-corp
- ☐ Government
- ☐ Partnership
- ☐ Association
- ☐ Nonprofit ☐ C-corp
- ☐ MEWA ☐ Church
- ☐ Union ☐ Trust

Group contacts

Group contact _____ Phone _____ Email _____ Fax _____

Billing contact _____ Phone _____ Email _____ Fax _____

Affiliates (to add more contacts, please attach additional pages)

Is your company affiliated with any other? ☐ Yes ☐ No **Will it be insured with PacificSource?** ☐ Yes, Common Ownership Form is attached ☐ No

Name of affiliate(s) _____ No. of employees _____

Address of affiliate(s) _____ Should each affiliate be billed separately? ☐ Yes ☐ No

Current insurance (required if you had prior coverage)

Medical

Carrier _____

Policy no. _____

Term date _____

Dental

Carrier _____

Policy no. _____

Term date _____

Who was eligible for your prior dental plan?

☐ Children only ☐ Adults and children

Existing workers' compensation

Carrier _____

Policy no. _____

Medical benefit information

The medical policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the ACA for small groups. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Contact your broker or let your PacificSource representative know if you wish to purchase a stand-alone dental care product.

Please select no more than four plans for your group members to choose from. Need some guidance? Please contact your sales representative with questions.

Navigator

☐ Platinum 500
☐ Platinum 500 VH
☐ Gold 1000
☐ Gold 1000 VH
☐ Gold 2000
☐ Gold 2000 VH
☐ Gold 3000
☐ Gold 3000 VH
☐ Gold HSA 3400
☐ Silver 3000
☐ Silver 4500
☐ Silver 4500 VH
☐ Silver 5500
☐ Silver 5500 VH
☐ Silver 6500
☐ Silver 6500 VH
☐ Silver HSA 3500
☐ Silver HSA 6000
☐ Bronze 7500
☐ Bronze 10600
☐ Bronze 10600 VH
☐ Bronze HSA 8300

Dental Benefit Information

☐ Dental Choice Core
☐ Dental Choice 0-20-50 750
☐ Dental Choice 0-20-50 1000
☐ Dental Choice 0-20-50 1500
☐ Dental Choice Plus 0-20-50 25-1000
☐ Dental Choice Plus 0-20-50 25-1500
☐ Dental Choice Plus 0-20-50 50-1000
☐ Dental Choice Plus 0-20-50 50-1500
☐ Kids Dental Choice 0-20-50 (coverage for members age 18 and younger)
☐ Kids Dental Choice 20-40-50 (coverage for members age 18 and younger)

Billing structure

Billing structure (check one): ☐ Age banded rates (based on age) ☐ Tiered rates (based on family composition)

Employer premium contribution (the amount the employer will contribute toward the employee and dependent premium)

Medical: ☐ % ☐ $ Employee _____ Dependent _____

Dental: ☐ % ☐ $ Employee _____ Dependent _____

Eligibility

Probationary waiting period

☐ 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)
☐ Other _____

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

☐ Eligible that day
☐ Must wait until the first day of the following month or 91st day, whichever comes first (default if not marked)

Initial enrollment: Will the probationary period be waived at initial enrollment? ☐ Yes ☐ No

Minimum hours

How many hours per week must employees work to be eligible for coverage?
Hours per week _____

Eligible members

Plan covers:
☐ Employee + spouse/domestic partner + children
☐ Employee only

HSA, HRA, FSA, COBRA administration, EAP, or POP

Check accounts your group has ☐ HSA ☐ HRA ☐ FSA ☐ COBRA administration ☐ EAP ☐ POP

If your accounts include COBRA administration, is your COBRA administered by PacificSource Administrators, Inc.? ☐ Yes ☐ No

If your COBRA account is not administered by PacificSource Administrators, should COBRA members be on a separate bill from employees? ☐ Yes ☐ No

Billing should be sent to: ☐ Employer group ☐ Third-party administrator

Employer contribution to HRA or HSA _____

Third-party administrator name _____ Phone _____

Mailing address _____

City _____ State _____ Zip _____ Email _____

People to be insured

1. _____ Total number of employees (full-time, part-time, owner, partner, principal, probationary, and waiver; exclude continuation)
2. _____ Total number of former employees currently on continuation or retiree coverage with your group health plan (submit Employee Enrollment and Waiver Form)

A. _____ TOTAL number of 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 Employee Enrollment and Waiver Form)
   *Qualified coverage: Employer Plan, Medicare, Medicaid, VA/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 number of EMPLOYEES NOT ENROLLING: Add numbers 3 through 6 above

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

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

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

Medicare coordination (TEFRA): Did you employ 20 or more employees each working day each of 20 or more calendar weeks in the **current or preceding calendar year?** ☐ Yes ☐ No

COBRA: Did you employ 20 or more total employees (full-time, part-time, seasonal) at least 50% of your business days **in the preceding calendar year?** ☐ Yes ☐ No

Employees on continuation of coverage (COBRA or USERRA):
Are any enrolling members covered under continuation on this plan? ☐ Yes ☐ No
If yes, Employee Enrollment and Waiver Form must be submitted for each employee on continuation.

RETIREE: Is group coverage available to retirees? ☐ Yes ☐ No
Is the group a local government (school, city, county)? ☐ Yes ☐ No

Approval is dependent on PacificSource policy and approval. If you offer health or dental coverage to your retirees, please attach the requirements and employer premium contribution if any.

Requirements—must be submitted prior to policy effective date

- ☐ Group Master Application
- ☐ Copy of sold rates
- ☐ Member employee enrollment and waiver information
- ☐ Binder payment (estimated first month premium) *Refunded if coverage not effectuated*
- ☐ Electronic Funds Transfer Form, optional
- ☐ Common Ownership Form, if applicable
- ☐ Group Identification Form, if applicable

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.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

If you type your name below, you understand that you are electronically signing this document and agree your electronic signature is the legal equivalent of your manual signature on this application.

Group representative (printed) _____ **Title** _____

Group representative signature _____ **Date** _____

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

Producer name (printed) _____ **PacificSource producer no.** _____

Producer signature _____ **Date** _____

What happens next?

1. You'll get an email with information to help you administer the plan.
2. You'll get the contract and a handbook in the mail.
3. We'll send your employees their ID cards.

If additional information is needed, a PacificSource representative will contact you. Please keep a copy of this application for your records.

Discrimination is against the law

PacificSource Health Plans and PacificSource Community Health Plans ("PacificSource") complies with applicable Federal civil rights laws, including Section 1557 of the Affordable Care Act. PacificSource does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)), age or disability. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:

Language assistance services

PacificSource will provide language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:

- Electronic and written translated documents
- Qualified interpreters
- Appropriate auxiliary aids and services for individuals with disabilities (including individuals' companions with disabilities) to ensure effective communication

Appropriate auxiliary aids and services may include:

- Qualified interpreters, including American Sign Language interpreters
- Video remote interpreting
- Information in alternate formats (including but not limited to large print, recorded audio, and accessible electronic formats)

Reasonable modifications

PacificSource will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

To access our language assistance services, auxiliary aids and services, and for assistance in getting a reasonable modification, please contact Customer Service at **888-977-9299,** TTY: 711. We accept all relay calls.

Continued >

Contact our commercial Customer Service team:

Phone
Toll-free: 888-977-9299
TTY: 711
We accept all relay calls.

Email
CS@PacificSource.com

PacificSource.com

Contact our Medicare Customer Service team:

Oct. 1 – Mar. 31:
8:00 a.m. – 8:00 p.m.,
seven days a week

Apr. 1 – Sept. 30:
8:00 a.m. – 5:00 p.m.,
Monday – Friday

Phone
Toll-free: 888-863-3637
TTY: 711
We accept all relay calls.
En Español: 866-281-1464

Email
MedicareCS@PacificSource.com

Medicare.PacificSource.com

PacificSource

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with PacificSource's Section 1557 Coordinator.

Phone: **888-977-9299,** TTY: 711. We accept all relay calls.

Email: 1557Coordinator@PacificSource.com

Mail: PacificSource
PO Box 7068
Springfield, OR 97475

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

Electronically: OCRPortal.hhs.gov

Mail: U.S. Department of Health & Human Services
200 Independence Avenue, S.W., Room 509F
Washington, D.C. 20201

Notice of availability of language assistance services and auxiliary aids and services

English

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-431-4135 (TTY: 800-735-2900) or speak to your provider.

አማርኛ
Amharic

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 800-431-4135 (TTY: 800-735-2900) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

العربية
Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 800-431-4135 أو تحدث إلى مقدم الخدمة (800-735-2900)

Bantu-Kirundi

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 800-431-4135 (TTY: 800-735-2900).

ភាសាខ្មែរ
Cambodian
Non-Khmer

សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃដែរ។ ហៅទូរសព្ទទៅ 800-431-4135 (TTY: 800-735-2900) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

中文
Simplified
Chinese

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800-431-4135（文本电话：800-735-2900）或咨询您的服务提供商。

中文
Traditional
Chinese

注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 800-431-4135（TTY：800-735-2900）或與您的提供者討論。

Cushite-Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-431-4135 (TTY: 800-735-2900).

Deutsch
German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-431-4135 (TTY: 800-735-2900) an oder sprechen Sie mit Ihrem Provider.

فارسی
Farsi

صحبت می‌کنید، خدمات پشتیبانی فارسی توجه: اگر زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور 800-431-4135 رایگان موجود می‌باشند. با شماره تماس بگیرید یا با (تله‌تایپ: 800-735-2900) ارائه‌دهنده خود صحبت کنید.

Français French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-431-4135 (ATS : 800-735-2900).

Italiano
Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-431-4135 (TTY: 800-735-2900).

日本語
Japanese

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。800-431-4135（TTY：800-735-2900）までお電話ください。または、ご利用の事業者にご相談ください。

한국어
Korean

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800-431-4135 (TTY: 800-735-2900) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

ລາວ
Laotian

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-431-4135 (TTY: 800-735-2900) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 800-431-4135 (टटिविइ: 800-735-2900) ।

Norwegian

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 800-431-4135 (TTY: 800-735-2900).

Pennsylvania Dutch

Wann du Deitsch (Pennsylvania German/Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800-431-4135 (TTY: 800-735-2900).

ਪੰਜਾਬੀ
Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 800-431-4135 (TTY: 800-735-2900) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 800-431-4135 (TTY: 800-735-2900).
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-431-4135 (TTY: 800-735-2900) или обратитесь к своему поставщику услуг.
Srpsko-hrvatski Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-431-4135 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 800-735-2900).
Soomaali Somali	FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 800-431-4135 (TTY: 800-735-2900) ama la hadal bixiyahaaga.
Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-431-4135 (TTY: 800-735-2900) o hable con su proveedor.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-431-4135 (TTY: 800-735-2900) o makipag-usap sa iyong provider.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-431-4135 (TTY: 800-735-2900).
українська мова Ukrainian	УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 800-431-4135 (TTY: 800-735-2900) або зверніться до свого постачальника.
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800-431-4135 (Người khuyết tật: 800-735-2900) hoặc trao đổi với người cung cấp dịch vụ của bạn.