

# Small Group Master Application – Oregon

For groups of 1-50 employees



## Employer information

Legal name of group _____	Effective date _____	<b>Form of organization</b> (check all that apply)  Limited liability company Sole proprietorship Subchapter S-corp Government Partnership Association Nonprofit MEWA Union C-corp Church Trust
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 _____		

## Group contacts

Group contact _____	Phone _____	Email _____	Fax _____
Billing contact _____	Phone _____	Email _____	Fax _____

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

<b>Is your company affiliated with any other?</b>	Yes	No	<b>Will it be insured with PacificSource?</b>	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	Silver 3500	Bronze 7500
Gold 1000	Silver 4500	Bronze HSA 8300
Gold 1500	Silver 5000	Standard Gold
Gold 2000	Silver 5500	Standard Silver
Gold 2500	Silver 6500	Standard Bronze
Gold 3500	Silver HSA 3500	
Gold HSA 3500	Silver HSA 5500	

### Voyager

Platinum 500	Silver 3500	Bronze 7500
Gold 1000	Silver 4500	Bronze HSA 8300
Gold 1500	Silver 5000	Standard Gold
Gold 2000	Silver 5500	Standard Silver
Gold 2500	Silver 6500	Standard Bronze
Gold 3500	Silver HSA 3500	
Gold HSA 3500	Silver HSA 5500	

## Dental benefit information

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

## Billing structure/SHOP eligibility

**Billing structure:** Tiered rates (based on family composition)

Small Business Health Options Program (SHOP) enrollment. *If yes, please complete the state-specific SHOP eligibility form.*

## 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 the 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](mailto:CS@PacificSource.com)

## [PacificSource.com](https://www.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](mailto:MedicareCS@PacificSource.com)

## [Medicare.PacificSource.com](https://www.Medicare.PacificSource.com)



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](mailto: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](https://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 (800-735-2900) أو تحدث إلى مقدم الخدمة

### 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 ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ 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 Sprachassistentendienste 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 رایگان موجود می‌باشند. با شماره 800-431-4135 تماس بگیرید یا با (800-735-2900) (تله‌تایپ: 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 दनिहोस्: तपाइंले नेपाली बोलनुहुन्छ भने तपाइंको नमिति भाषा सहायता सेवाहरू नशिलुक रूपमा उपलब्ध छ । फोन गर्नुहोस् 800-431-4135 (टटिविडि: 800-735-2900) ।

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

**Pennsylvania Dutch**  
Wann du Deitsch (Pennsylvania German/Dutch) schwetzsch, 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 ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੇਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 800-431-4135 (TTY: 800-735-2900) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।



<b>Romanian</b>	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 800-431-4135 (TTY: 800-735-2900).
<b>РУССКИЙ</b> 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.
<b>Srpsko-hrvatski</b> 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).
<b>Soomaali</b> 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.
<b>Español</b> 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.

<b>Tagalog</b>	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang 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.
<b>Thai</b>	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-431-4135 (TTY: 800-735-2900).
<b>українська мова</b> Ukrainian	УВАГА: Якщо ви розмовляєте українською мовою, 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.
<b>Việt</b> 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.

PacificSource Health Plans (commercial) | PacificSource Community Health Plans (Medicare)

PacificSource Community Health Plans is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid). Enrollment in PacificSource Medicare depends on contract renewal.