

# Small Group Master Application – Washington

For groups of 1-50 employees



## 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  
MEWA  
Union  
C-Corp  
Church  
Trust

## Employer eligibility

To qualify for small group coverage the employer must have at least 1 but no more than 50 common law employees during the preceding calendar year as defined under applicable state and federal law. Exclusions include: a. A self-employed individual; b. A sole proprietor of the sponsoring business or the sole proprietor's spouse; c. An individual that wholly owns a corporation that is the sponsoring business, or wholly owns the corporation with his/her spouse (except a corporate officer who is an employee as defined in 26 CFR 31.3121(d)-1(b)); and d. A partner in a partnership sponsoring the plan or the partner's spouse (except a "bona fide partner" as defined by law in 45 CFR section 146.145(c)(2)).

## Group Contacts

Group Contact \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_  
Group Contact \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_  
Billing Contact \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_  
Billing Contact \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_

## Affiliates

**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 \_\_\_\_\_

### 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 agent 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

Gold 1000

Gold 1500

Gold 2000

Gold 2500

Gold 3500

Silver 3000

Silver 4500

Silver 5500

Silver 6500

Bronze 8150

Gold HSA 3000

Silver HSA 3000

Silver HSA 4500

Silver HSA 5500

Bronze HSA 6000

Bronze HSA 6900

### Voyager

Platinum 500

Gold 1000

Gold 1500

Gold 2000

Gold 2500

Gold 3500

Silver 3000

Silver 4500

Silver 5500

Silver 6500

Bronze 8150

Gold HSA 3000

Silver HSA 3000

Silver HSA 4500

Silver HSA 5500

Bronze HSA 6000

Bronze HSA 6900

## Billing Structure/SHOP Eligibility

**Billing Structure (check one):**    Age banded rates (based on age)    Composite

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 towards the employee and dependent premium)

**Medical:** 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/registered or unregistered domestic partner + children
- Employee + children
- Employee only

## 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 \_\_\_\_\_ 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 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 comprised 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, State 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.

## Requirements—Must Be Submitted Prior to Policy Effective Date

Group Master Application

Copy of Sold Rates

Member Employee Enrollment and Waiver Information

Binder Payment (est. first month premium) *Refunded if coverage not effectuated*

Electronic Funds Transfer Form, if you want PacificSource to withdraw the monthly premium from a bank account

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 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 Number** \_\_\_\_\_

**Producer Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### Your Application Will Be Processed Soon

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 Member 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 complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### PacificSource:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (888) 977-9299 or, for TTY users, (800) 735-2900, 7:00 a.m. to 5:00 p.m.

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 Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, (888) 977-9299, TTY 711, fax (541) 684-5264, or email [crc@pacificsource.com](mailto:crc@pacificsource.com). Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the PacificSource Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [OCRPortal.hhs.gov/ocr/portal/lobby.jsf](http://OCRPortal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at:

U.S. Department of Health and Human Services  
 200 Independence Avenue, SW  
 Room 509F, HHH Building  
 Washington, DC 20201  
 (800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at [HHS.gov/ocr/office/file/index.html](http://HHS.gov/ocr/office/file/index.html).

Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ (888) 977-9299 (መስማት ለተሳናቸው፡ 711)።
Arabic	ملاحظة: مقرب لصرتا. ن اجم اب كل رفاوتت ةيوع للا ادع اس مل ا تامدخ ن اف، ة ل ل ا ركذا ثدحتت تنك اذا :ظوح لم (711: م كبل او مصل ا فتاه حق) (888) 977-9299
Bantu	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (888) 977-9299 (TTY: 711).
Cambodian	ប្រសិនបើ ប្រយ័ត្ន៖ សិនជាអ្នកនិយាយ ភាសាខ្មែរ, សម្រាប់ជំនួយផ្នែកភាសា ដោយមិនគិតល្អធុន គឺអាចមានសំរាប់បម្រើអ្នក។ ចូរ ទូរស័ព្ទ (888) 977-9299 (TTY: 711)។
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (888) 977-9299 (TTY: 711)。

Cushite-Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (888) 977-9299 (TTY: 711).
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez (888) 977-9299 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (888) 977-9299 (TTY: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (888) 977-9299 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(888)977-9299(TTY:711) まで、お電話にてご連絡ください。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (888)977-9299 (TTY: 711)번으로 전화해 주십시오.
Laotian	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ລ່ວງລ່າງ, ແມ່ນມີອັ້ນໃຫ້ທ່ານ. ໂທ (888) 977-9299 (TTY: 711).
Nepali	ध्यान दिनुहोस्: तपाइंले नेपाली बोल्नुहुन्छ भने तपाइंको नमिति भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (888) 977-9299 (टटिवाइः 711) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistanstjenester tilgjengelige for deg. Ring (888) 977-9299 (TTY: 711).
Pennsylvania Dutch	Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call (888) 977-9299 (TTY: 711).
Persian-Farsi	دش اب یم مه ارف امش ی ارب ناگی اار ترو ص ب ی ن اب ز ت ا ل ی هست ، د ی ن ک یم و گ ت ف گ ی س ر ا ف ن اب ز ه ب ر گ ا : ه ج و ت د یر ی گ ب س ا م ت (888) 977-9299 (TTY: 711)
Punjabi	ਧਿਆਨ ਦਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵੱਚਿ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (888) 977-9299 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ।
Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (888) 977-9299 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (888) 977-9299 (телетайп: 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (888) 977-9299 (TTY–Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 977-9299 (TTY: 711).
Tagalog	UNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (888) 977-9299 (TTY: 711).
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (888) 977-9299 (TTY: 711).
Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (888) 977-9299 (телетайп: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (888) 977-9299 (TTY: 711).