

Small Group Master Application – Montana

For groups of 1-50 employees



Employer Information

Legal Name of Group _____	Effective Date _____	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
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)

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 standalone product. Contact your agent or let your PacificSource representative know if you wish to purchase a standalone 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

Silver 3000

Silver 4500

Silver 4500 VH

Silver 5500

Silver 5500 VH

Silver 6500

Silver 6500 VH

Bronze 8150

Bronze 8700

Gold HSA 3000

Silver HSA 3000

Silver HSA 4500

Silver HSA 5500

Bronze HSA 7000

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

(For members through age 18)

Kids Dental Choice 20-40-50

(For members through age 18)

Cosmetic Orthodontia

(minimum enrollment requirements)

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 Admin EAP POP
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 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.

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, 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 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 Number** _____

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 ("PacificSource") 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.

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. 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, 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 <https://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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Amharic	ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የPacificSource Health Plans ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአካፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። (888) 977-9299 ይደውሉ።
Arabic	يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال PacificSource Health Plans. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك (888) 9299-977 من دون أي تكلفة. اتصل بـ

Bantu-Kirundi	Iyi notice ifise akamaro k'ingenzi. Iyi notice ifise akamaro kingene utegerezwa gusaba canke ivyerekeye PacificSource Health Plans, ucuraba ko ibikenewe kuriyi notice, ushobora gufata umwanzuro ukungene wokurikirana ubuzima bwawe uburihiye. Kandi ukongera kugira uburenganzira bwo kwigenga kuronka amakuru n'ubufasha mu rurimi gwawe atacyo utanze. Hamagara (888) 977-9299.
Cambodian-Mon-Khmer	បសចក្រីជូន័ន័ណឹងបនេះ ម្តងពី័័ម្តងយា៉ា ងសំខាន់ ។ បសចក្រីជូន័ន័ណឹងបនេះ ម្តងពី័័ម្តងយា៉ា ងសំខាន់ អុំពី័ប្លង់ដររេ ឬ ការរ៉ា រង រស់អ្នកតាមរយៈ PacificSource Health Plans។ សូមដ័សងរកកាលរិបចេ័សំខាន់ចា់ចំ បៅកនុងបសចក្រីជូន័ន័ណឹងបនេះ ។ អ្នកប្រ័សែលជាបុ័្តែការរបចេញសកមមភាព ័លក់ណែ័ថ្ងៃជាក់ចាស់នានា បែ័មបីនីងរកាេកការរ៉ា រង សុខភាពរស់អ្នក ឬបុ័ក់ជំនួយបចេញថ្ងៃ ។ អ្នកម្តងសិេធិេ័លពី័័ម្តងបនេះ នឹងជំនួយបៅកនុងភាសារស់អ្នកបោយមិនអ្សលុយប ើយ ។ សូមេ្នរស័ពទ (888) 977-9299[។
Chinese	本通知含有重要的訊息。本通知對於您透過 PacificSource Health Plans 所提出的申請或保險有重要的訊息。請在本通知中查看重要的日期。您可能要在特定的截止日期之前採取行動，以保留您的健康保險或有助於省錢。您有權利免費以您的母語得到幫助和訊息 請致電 (888) 977-9299。
Cushite-Oromo	Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa PacificSource Health Plans tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa (888) 977-9299 tii bilbilaa.
French	Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de PacificSource Health Plans. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez (888) 977-9299.
German	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch PacificSource Health Plans. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (888) 977-9299.
Italian	Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso PacificSource Health Plans. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama (888) 977-9299.
Japanese	この通知には重要な情報が含まれています。この通知には、PacificSource Health Plans の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。(888) 977-9299までお電話ください。

Russian	Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через PacificSource Health Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (888) 977-9299.
Serbo-Croatian	U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko PacificSource Health Plans. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite (888) 977-9299.
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de PacificSource Health Plans. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (888) 977-9299.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng PacificSource Health Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (888) 977-9299.
Thai	ประกาศนี้มีข้อมูลสำคัญประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอเขตประกันสุขภาพของคุณผ่าน PacificSource Health Plans ดูกำหนดการในประกาศนี้คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่ายโทร (888) 977-9299.
Ukrainian	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через PacificSource Health Plans. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону (888) 977-9299.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin nộp hoặc hợp đồng bảo hiểm qua chương trình PacificSource Health Plans. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình hoàn toàn miễn phí. Xin gọi số (888) 977-9299.