# Group Renewal Confirmation Form

**Important!** Complete and submit this renewal form to PacificSource even if no changes are needed.
**Small group** renewals can be submitted electronically through InTouch for Employers or InTouch for Agents. If we do not receive your renewal confirmation by **the 20th of the month prior to your renewal date**, your coverage will automatically renew based on the plan design shown in your renewal exhibit.

Group name _____ Group no. _____ Renewal date _____

## Renewal options

**Option 1**

☐ **Renew on current plan design.** All group contract and eligibility information remains unchanged, except as required by regulation. **Skip to signature line page 2.**

**Option 2**

☐ **Make changes using this form.** *(Any section left blank will remain unchanged.)*

## Eligibility changes (Any section left blank will remain unchanged.)

**Probationary waiting period** (Please select one)

☐ Date of hire (premium prorated first month)

☐ First of the month following 60 days

☐ First of the month following date of hire

☐ 90 calendar days; effective on 91st calendar day (premium prorated first month)

☐ First of the month following 30 days

☐ Other _____

**If the last day of the probationary period falls on first day of the month, when will the new employee 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)

**Minimum hours for eligibility**

Enter the minimum number of hours per week employees must work to be eligible for coverage. Hours per week _____

**Employer premium contribution** (the amount the employer will contribute toward the employee and dependent premium) Indicate a percentage (%) or dollar amount ($).

Medical: Employee _____% Dependent _____% Dental: Employee _____% Dependent _____%

**Does your organization offer an HRA?**

☐ No ☐ Yes; if yes, what does the employer contribute to account? $ _____

**Eligible members covered by this plan:**

☐ Employee + spouse/registered or unregistered domestic partner + children
☐ Employee only (option only for small groups)
☐ Employee + children only (option only for large groups)

*Continued on reverse >*

## Benefit changes (Any section left blank will remain unchanged.)

**Large group** (attach final renewal rates)

☐ Renew current medical plan design(s). ☐ Renew current dental plan design.
☐ Change to the plan(s) listed below. Enter the plan name(s) exactly as shown on your renewal notice. (i.e., Navigator 1000+25_20).

Medical/Rx plan(s) _____

_____

Vision plan _____ Dental plan _____

Orthodontia max ☐ $1,000 ☐ $1,500 Other/custom (please specify) _____

**Small group**

☐ Renew current medical plan design(s). ☐ Renew current dental plan design.
☐ Change to the plan(s) below. Enter the plan name(s) exactly as shown on your renewal notice (i.e., Navigator Gold 1000).

* Billing structure (select one): ☐ Age-banded rates (based on age) ☐ Tiered rates (ID, OR & MT) *For Idaho and Montana groups only

Medical plan(s) _____

_____

Dental plan _____

☐ Cosmetic Orthodontia (Orthodontia is available to groups in Idaho, Oregon, and Montana with 26 or more enrolled employees)

*The Affordable Care Act (ACA) requires small groups that offer health coverage to provide pediatric dental coverage. If your group does not have dental coverage through another insurer, we recommend adding a family or pediatric dental plan.*

## Termination

Terminate this coverage at renewal: ☐ Medical ☐ Dental ☐ Other _____ ☐ All lines of coverage

Reason _____ New carrier(s) _____

## Signature (please read carefully)

- I acknowledge that retroactive changes to benefits or eligibility are not allowed. Any off-renewal change requests will be effective the first of the month following the date that PacificSource receives the written request.
- I understand that eligibility standards must be applied consistently for all employees and their eligible dependents. I agree to make all coverage options available to all eligible employees who satisfy the hourly and probationary wait requirements.
- I understand that it is my responsibility to comply with the eligibility provisions of the Affordable Care Act and any related state or federal guidance. Noncompliance may result in the group penalty from federal agencies.
- I understand that I am accepting all changes outlined in the Notice of Change letter or as required by federal regulations.

Print Name _____

Signature _____ Title _____ Date _____

**Signature and date are required.**

Submit by location to:

**Oregon**
Oregon Sales@PacificSource.com
Fax: (541) 225-3645
PO Box 7068,
Springfield, OR 97475-0068

**Idaho**
IdahoSales@PacificSource.com
Fax: (208) 344-4262
408 E. Parkcenter Blvd, Ste 100
Boise, ID 83706

**Montana**
MontanaSales@PacificSource.com
Fax: (406) 422-1010
828 Great Northern Blvd, Ste 101
Helena, MT 59601

Renew online using InTouch for Employers at **InTouch.PacificSource.com/employers/account/login** or InTouch for Agents at **InTouch.PacificSource.com/agents.** View benefit summaries at **PacificSource.com/plan-summaries.**