PacificSource HEALTH PLANS

Group Master Application
Idaho

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 Contact

Group Contact _____ Phone _____ Email _____ Fax _____

Billing Contact _____ Phone _____ Email _____ Fax _____

Affiliates

Is your company affiliated with any other? ☐ Yes ☐ No **If so, 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. _____

Benefit Information

Small Group
Indicate coverage with "yes" or "no."

☐ Yes ☐ No **Medical**..... Plan Name(s) _____

_____

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, PacificSource, or Your Health Idaho if you wish to purchase a stand-alone dental care product.

☐ Yes ☐ No **Dental**.....Plan Name _____

☐ Yes ☐ No **Cosmetic Orthodontia** (26+ enrolled employees)

☐ Yes ☐ No **SHOP Enrollment:** Do you want to request to be enrolled in the Small Business Health Options Program (SHOP)? If yes, you must also complete the state specific SHOP eligibility form.

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

Large Group
Indicate coverage with "yes" or "no."

☐ Yes ☐ No **Medical and Pharmacy**.....Plan Name(s) _____

☐ Yes ☐ No **Chiropractic Manipulations and Acupuncture** ....Number of Visits _____

☐ Yes ☐ No **Vision** .....Plan Name _____

☐ Yes ☐ No **Additional Accident**.....Amount $ _____

☐ Yes ☐ No **Dental**.....Plan Name(s) _____

☐ Yes ☐ No **Orthodontia** .....Lifetime Maximum _____

Employer Premium Contribution (The amount the employer will contribute towards 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 _____

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

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

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 (only for small group)
☐ Employee + children (only for large group)

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 _____ Address _____ Phone _____

People to Be Insured

1. _____ Total number of employees (full-time, part-time, owner, partner, principal, probationary, and waiver; exclude continuation)
2. _____ Total no. former employees currently on Continuation or Retiree with your group health plan (submit Application and Waiver of Coverage 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 Application and Waiver of Coverage 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

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

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

Approval 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).

Employees on continuation of coverage (COBRA, State or USERRA): Application and Waiver of Coverage Form must be submitted for each employee on continuation.

Name	Continuation Effective Date	Qualifying Event

Requirements—Must Be Submitted Prior to Policy Effective Date

☐ Group Master Application ☐ Copy of Sold Rates ☐ Member 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

Signature—Please Read Carefully

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.

I affirm that I have read this application in its entirety, and that the information I have provided is complete and correct. I understand that if this application contains any intentional misrepresentation of material fact or fraud, PacificSource Health Plans may modify or cancel the contract, and/or take any other legal action available by law. I will promptly inform PacificSource Health Plans in writing if anything happens before coverage takes effect that makes the information I have provided on this application incomplete or incorrect.

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

Agent's Name (Printed) _____ **Agent No.** _____

Agent's Signature _____ **Date** _____

What Happens After You Submit Your Group Application

We'll begin processing the applications for your group. In the coming weeks, you'll receive a few things from us.

1. We'll send you an email with information about your plan, our tools to help you administer the plan, and PacificSource contacts who can assist you.
2. We'll also send your contract and a Member Handbook that you can share with employees.
3. Your employees can look for their ID cards in the mail close to the date your plan begins.

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. 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, 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.

Amharic	**ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ** (888) 977-9299 **(መስማት ለተሳናቸው**: 711).
Arabic	**ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (888) 977-9299 (رقم هاتف الصم والبكم: 711).
Bantu	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (888) 977-9299 (TTY: 711).
Cambodian	បើ ប្រយ័ត្ន៖ សិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (888) 977-9299 (TTY: 711).
Nepali	ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नम्तिभाषा सहायता सेवाहरू नःशिुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (888) 977-9299 (टटिविाइ: 711) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring (888) 977-9299 (TTY: 711).
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 (888) 977-9299 (TTY: 711).
Persian-Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با (888) 977-9299 (TTY: 711) تماس بگیرید.
Punjabi	ਧਆਿਨ ਦਓਿ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਚਿ 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).