Large Group Master Application – Oregon

For groups of 51+ 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
- C-Corp
- MEWA
- Church
- Union
- Trust

Group Contact (To add more contacts, please attach additional pages)

Group 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 ______________

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

Indicate coverage with "yes" or "no".

Yes	No	**Medical and Pharmacy**	Plan Name(s)	________
Yes	No	**Chiropractic Manipulations and Acupuncture**	Maximum $	________
Yes	No	**Vision**	Plan Name	________
Yes	No	**Additional Accident**	Amount $	________
Yes	No	**Dental**	Plan Name(s)	________
Yes	No	**Orthodontia** (26+ enrolled employees)	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 ________

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 + children

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 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 (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

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.

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** ______________________

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. 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 ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (888) 977-9299 (TTY: 711).
Nepali	ध्यान दिनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (888) 977-9299 (टिटिवाइ: 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، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (888) 977-9299 (TTY: 711) تماس بگیرید.
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ 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).