MONTANA – NFIB GROUP MASTER APPLICATION
☐PacificSource Health Plans HMO
☐PacificSource Health Plans (PPO)

PacificSource

NFIB The Voice of Small Business®

Effective Date of This Policy:_____ 20___ *(Must be received by PacificSource by 5th of prior month.)*

Legal Name of Group (will appear on contract):_____

DBA Name (will appear on bills/ID cards) *(35 character limit)*:_____

Business Street Address:_____

City:_____ Zip Code:_____ County:_____

Billing Address (if different than above):_____

City:_____ State:_____ Zip Code:_____

Phone No.:_( )_____ Fax No.:_( )_____

Group Admin–First Name:_____ Last Name:_____

Group Admin E-Mail Address:_____ *(used for important communications only; not shared)*

Billing Contact–First Name:_____ Last Name:_____ E-Mail:_____

Name(s) of All Owners and Partners:_____

Federal I.D. Number:_____ Name of State Company is Headquartered:_____

Business Inception Date:_____ SIC or NAICS Code:_____ NFIB Member No.:_____

Nature of Business *(description of work involved):*_____

Form of Organization (check all that apply): ☐Sole Proprietorship ☐Partnership ☐Government ☐Union ☐Church ☐Association ☐MEWA ☐Trust ☐C-Corp ☐Subchapter S-Corp ☐Limited Liability Company ☐Non-Profit

AFFILIATES

Is your company affiliated with any other company? ☐Yes ☐No Will they also be insured with PacificSource? ☐Yes ☐No

Name of Affiliate(s):_____ Number of Employees:_____

Address of Affiliate(s):_____ ☐Attach the Common Ownership Form

HSA, HRA, FSA, COBRA ADMINISTRATION, OR EAP

Check any accounts your group has: ☐HSA ☐HRA ☐FSA ☐COBRA Admin ☐EAP

Company Name_____ Contact_____ Phone_____ Fax_____ Email_____

Employer Contribution to HRA or HSA_____ If HSA Bank, do you want an integrated bill? ☐Yes ☐No

DOCUMENT DISTRIBUTION

Billing: If multiple locations/classifications: ☐Combined bill ☐Separate bills mailed to: __main group __each location

ID Cards: Mailed directly to each covered employee's home (or custodial parent's home applicable).

Book Electronic Copy: An electronic copy of your member handbook ***will be e-mailed to you*** after your group has been processed. This searchable electronic format can be saved to your intranet or internal computer system for employee access.

Book on InTouch Web Portal: Group Administrators and their covered members can also log into InTouch at PacificSource.com to access this quick, easy, searchable handbook and other helpful information online 24/7 from anywhere in the world.

Book Hardcopy: In addition to the electronic copy, a single printed office reference copy will be provided to the employer.

Language: Do you need Spanish benefit summaries? ☐Yes ☐No Other language needs:_____

REQUIREMENTS – MUST BE SUBMITTED PRIOR TO POLICY EFFECTIVE DATE

☐Group Master Application ☐Copy of quoted rates ☐Enrollment Applications (Health Statements) ☐Waiver Forms

☐Electronic Funds Transfer form, if you want PacificSource to withdraw your monthly premium from your bank account

☐Check for estimated first month's premium on all requested lines of coverage–Amount: $_____
Acceptance of premium does not imply coverage. If coverage does not go into effect, the deposit will be refunded.

☐ Please mail to PO Box 7068, Springfield, OR 97475, fax to 541.225.3645, or e-mail to MontanaGroupSales@pacificsource.com.

EMPLOYER CONTRIBUTION TOWARDS PREMIUM

Minimum Contribution Requirement: *If dual choice base/buy-up, minimum employer contribution is based on the base plan.*

Medical*: Employee_____% Dependent_____% *Minimum allowed is 75% employee/0% dependent (or 50%/50%).*

**If employer contribution differs by job classification or other factors, please list all contribution variations (attach page if needed).*

Small Employer: Will any portion of the premium be paid by or on behalf of the employer, either directly or through wage adjustments or other means of reimbursement? ☐Yes ☐No

Is this health benefit plan part of a plan or program for the purposes of Internal Revenue Codes 106, 125, or 162? ☐Yes ☐No

PROBATIONARY PERIOD AND PEOPLE TO BE INSURED

Completed member enrollment applications must be submitted for all individuals to be insured, including those on COBRA and waivers. *Individuals currently eligible and for whom applications are not received will be considered late enrollees.*

HOURLY AND WAITING/PROBATIONARY PERIOD: Employer determines hours and days worked for eligibility, subject to the following:

- Must be "first of the month" following between 1 and 365 days *(not to exceed 365 days total)* and 20 and 40 hours.
- If employer group has both health and dental coverage with PacificSource, member eligibility and employer contribution must match.
- Minimum participation for 2-5 medical subscribers is 100%; 6 or more medical subscribers is 75%; 15 or more dental subscribers is 75%.

We recommend you either offer coverage to all employees that meet your plan's hourly requirement and probationary waiting period **or** conduct nondiscrimination testing according to provisions of IRS Code 105(5) to confirm your plan complies with the provisions of Public Health Service Act section 2716 as amended by Patient Protection and Affordable Care Act section 1001(5). The Department of Labor has suggested violators can face fines of up to $100 a day per employee discriminated against. Contact your attorney or CPA for assistance.

- Name of Class_____Hours_____Days_____
- Name of Class_____Hours_____Days_____
- If the last day of the probationary period falls on the first day of the month, will the new employee be eligible for coverage that day or have to wait until the first day of the following month? ☐ Eligible that day ☐ Must wait *(If not answered, default is "must wait.")*

1. _____Number of **all** employees *(include full-time, part-time, owner, partner, principal, probationary, & waiver; exclude COBRA)*
2. _____Number of former employees currently on COBRA with your group health plan *(must submit applications)*

A. TOTAL EMPLOYEES – Add numbers 1 and 2 above:_____

3. _____Number of employees who do not qualify due to hourly requirement
4. _____Number of employees who do not qualify due to waiting period requirement
5. _____Number of employees waiving coverage due to other group coverage (*waiver forms or applications must be submitted)*
6. _____Number of employees not insured for reasons not stated above *(requires prior approval from PacificSource)*

Please explain reason *(e.g., classification not eligible, chose not to participate):*_____

B. TOTAL EMPLOYEES NOT ENROLLING – Add numbers 3 through 6 above:_____

C. TOTAL EMPLOYEES ENROLLING, including COBRA – Subtract B from A above:_____

D. DOMESTIC PARTNER – ☐None ☐Same Gender Only Affidavit ☐Any Gender Affidavit (same or opposite gender)

E. INITIAL ENROLLMENT – Will the initial group of employees be required to meet the waiting period? ☐Yes ☐No

F. LEAVE – Can employees continue coverage while on an employer-authorized reduction of hours (12-month max)? ☐Yes ☐No

G. SERVICE AREA – Do all employees reside within the PacificSource service area? ☐Yes ☐No

H. OTHER FUNDING – Does your company fund the medical benefits under the deductible (buy-down or HRA)? ☐Yes ☐No

I. ERISA – Is this plan for a group comprised of employees of a government entity or church that is not subject to ERISA? ☐Yes ☐No

J. COBRA – Did you employ 20 or more total employees (full-time, part-time, and seasonal) on at least 50 percent of your business days in the ***preceding calendar year***? ☐Yes ☐No If yes, list the employees on COBRA coverage *(applications must also be submitted):*

Name	COBRA Effective Date	Qualifying Event

If your group is COBRA eligible, do you want PacificSource to do your administration? ☐Yes ☐No *If yes, complete attached.*

- Current number of enrolled COBRA members:_____
- Current number of pending COBRA members:_____
- Are any COBRA appeals in process? ☐Yes ☐No If Yes, Explain:_____
- A Paid thru report for all enrolled COBRA members is needed before members can be enrolled. Attached? ☐Yes ☐No
- Please e-mail cobra@pacificsource.com anytime a pending participant elects participation and payment is received.

EXISTING OR PRIOR INSURANCE – Submit copy of last billing statement showing employees' names.

Replacing existing group health insurance? ☐Health/Medical Insurance ☐Dental Insurance

Prior Carrier(s) Replacing:_____ Policy No.:_____ Phone No.:_____

Date Coverage Effective:_____ Date Coverage Terminated:_____ Is Coverage Still in Force? ☐Yes ☐No

Employees whose last names have changed in the past six months:_____

WORKER'S COMPENSATION

Name of Insurance Carrier:_____ Policy No.:_____ Phone No.:_____

Please provide information regarding any individuals not covered under your Worker's Compensation policy in the space below:

Name(s)	*Title(s)*	*Reason(s) Not Covered*

DISABILITY INFORMATION

Are any employees currently absent due to illness or injury, or currently receiving disability benefits? ☐Yes ☐No

Name of Disabled Person	*Date of Disability*	*Cause of Disability*	*Physician's Name, Address, & Phone No.*

BENEFIT INFORMATION

Medical Plan: ***Check ✓to indicate coverage selection(s).***

☐Option A – PPO 80+500 2000 VAR, Tiered Rx 20/40/60 MacB

☐Option B – HMO 1000+20/70 3500 VAR, Tiered Rx 20/40/60 MacB

☐Option C – Indemnity 2500 VAR, Tiered Rx 20/200+40/60 MacB

☐Option D – HSA 100+3000 E VAR, Integrated Rx

☐Option E – HSA 100+3000 NE VAR, Integrated Rx

☐Option F – HSA 100+5000 NE VAR, Integrated Rx

Deductible: If within the same calendar year deductible period, do you want your prior carrier deductible credited? ☐Yes ☐No

If yes, please have a prior carrier deductible report sent in secure electronic format to PacificSource.

Dual Choice: Minimum 10 enrolled employees. *If small group, one plan must be a high deductible of $2500 or more.*

Other Benefits:

AGENT INFORMATION

Agent:_____ Agency:_____ Agent No.:_____

PLEASE READ CAREFULLY

This is a request for group insurance; not a policy. Under no circumstances will coverage be in force until the policy is issued by PacificSource and accepted by the employer. The terms of the policy shall control in all cases once the policy is issued. I affirm the answers on this application are correct and understand the following:

- I acknowledge when two employees are married to each other and enroll as a family instead of separately, a waiver form or waiver section of the enrollment application must be completed for the spouse (can be signed be either the employee or spouse). The oldest employee will always be enrolled as the employee and the youngest as the spouse regardless of how the application is completed.
- Acceptance of premium or receipt of ID cards does not imply coverage. If coverage does not go into effect, deposit is refunded.
- I understand eligibility standards (e.g., probationary period, minimum hours, etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents (even owners).
- I agree to make all coverage options available to all eligible employees and dependents that satisfy eligibility requirements.
- I acknowledge benefits may be added or enhanced only at time of initial group application, at contract renewal, when required by law, or when PacificSource makes a carrier-wide decision to do so. I may reduce benefits off-renewal. Retroactive changes are not allowed and will not be effective prior to the first of the month following the date the request is received by PacificSource.
- I must submit this completed application prior to the requested effective date, or the policy effective date will be delayed.

Employer Signature	Date	Agent Signature	Date

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