



OFFICE

Group Number: _____
Med RL: _____ RX RL: _____
Trust Fee: <input type="checkbox"/> Attached <input type="checkbox"/> Waived

Renewal Application

Medical, RX, Dental and Vision plans offered under the Pacific Health Trust are underwritten and administered by Health Net Health Plan of Oregon, Inc., Guardian and VSP®, respectively.

Company Information

Effective Date Requested: _____

Association Membership: _____ Member since: _____

Company: _____ Tax ID: _____

DBA (if applicable): _____

Address: _____

City: _____ County: _____ ST: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Benefits Administrator Name: _____ Title: _____

Address (if different): _____

Phone: _____ Fax: _____ E-mail: _____

Billing Contact (if different): _____ Title: _____

Address (if different): _____

Phone: _____ Fax: _____ E-mail: _____

Type of Organization: Corporation Partnership Sole Proprietorship Other SIC Code: _____

Nature of Business: _____ Date of Inception: _____ Previous Medical Carrier: _____

Participation Requirements

Total employees: _____ Total working 20+ hours a week: Full-time _____ Part-time _____

Please check the appropriate box for total # of employees including: Full-time, Part-time and seasonal employees:

0-19 employees 20-99 employees 100+ employees

Number of employees eligible per employer guidelines to enroll in the plan: _____

Number of employees enrolling: _____ Number of dependents enrolling: _____

Number of employees waiving: _____

Employer Contribution and Eligibility Provisions

Employee Coverage: _____% of Monthly Rate OR \$ _____ toward Monthly Rate

Dependent Coverage: _____% of Monthly Rate OR \$ _____ toward Monthly Rate

Employees must enroll within 31 days of eligibility. Eligibility provisions may only be changed at annual contract renewal.

Eligible Employees: Regular active full-time employees scheduled to work at least _____ hours per week (min 20 hrs, max 40 hrs)

Newly Eligible Employees: First day of the month following _____ days from date of hire. (0, 30, 60, 90, 180)

Employees rehired within _____ (0 – 6) months are not required to complete a new probationary period.

COBRA

Are you subject to COBRA? Yes No

A group is subject to COBRA during the current calendar year if the group employed 20 or more employees on more than 50% of its typical business days in the preceding calendar year.

If Yes, Please Choose:

- Trust Administration (please complete a BenefitHelp Solutions Agreement and submit with your application)
- Self-Administration

Coverage Applied For (check plans that apply):

Enrollment Packets Needed: _____

Note: If benefits differ by class or location please indicate below or add an additional sheet.

Health Net Medical Plans

- Groups under 20 choose one plan
- Groups with 20+ enrolled may choose two plans (minimum of 3 enrolled in each plan)

<input type="checkbox"/> PPO 250 (\$15 / \$250 / 20% / \$1,000 LX) <input type="checkbox"/> PPO 500 (\$15 / \$500 / 20% / \$1,500 DX) <input type="checkbox"/> PPO 750 (\$20 / \$750 / 20% / \$2,500 DX) <input type="checkbox"/> PPO 1000 (\$25 / \$1000 / 20% / \$2,500 DX) <input type="checkbox"/> PPO 1500 (\$25 / \$1,500 / 20% / \$2,500 DX) <input type="checkbox"/> PPO 2500 (\$30 / \$2,500 / 20% / \$2,500 DX) <input type="checkbox"/> PPO 3000 (\$30 / \$3000 / 20% / \$9,000 DX) <input type="checkbox"/> PPO 50/50 \$0 Ded \$2,500 OOP Max (50-50 2,500) <input type="checkbox"/> PPO 50/50 \$0 Ded \$5,000 OOP Max (50-50-5,000) <input type="checkbox"/> HSA 1500 (HDHP \$1,500 / 20% / \$3,000 w/ 20% Rx)	Health Net RX Plan Choose one option <input type="checkbox"/> Rx \$10 / \$20 / \$40 <input type="checkbox"/> Rx \$15 / \$30 / \$50 <input type="checkbox"/> Rx \$10 / \$50 / \$75 <input type="checkbox"/> Rx \$15 / 35% / 50% - \$5,000 OOP Max <input type="checkbox"/> No Rx	VSP Vision Plan Choose one option <input type="checkbox"/> VSP \$0 / \$10 <input type="checkbox"/> VSP \$10 / \$25 <input type="checkbox"/> No Vision
<i>Note: Pharmacy & Vision enrollment must match the medical enrollment.</i>		
Guardian Dental Plans		
<input type="checkbox"/> Plan 1000 (\$1,000 Max) <input type="checkbox"/> Plan 1500 (\$1,500 Max) <input type="checkbox"/> Plan 2000 (\$2,000 Max)		<input type="checkbox"/> Plan 1000 w/ Ortho* <input type="checkbox"/> Plan 1500 w/ Ortho* <input type="checkbox"/> Plan 2000 w/ Ortho*
<i>*Orthodontia coverage is only available to groups of 10+ eligible employees</i>		
Optional Benefits: <input type="checkbox"/> COBRA Administration through BenefitHelp Solutions (\$1.76 per employee charge) <input type="checkbox"/> Domestic Partner Coverage (No Charge—Select to add benefit) Must select at initial effective date or at subsequent renewal. <input type="checkbox"/> Employee Assistance Program through RFL (\$0.75 per employee charge) <input type="checkbox"/> LifeBalance Card (\$1.00 per employee charge)	Optional Benefits: <input type="checkbox"/> 24 Hour Owner Coverage – Please attach a list including First / Last names for all owner / officers excluded from Workers Compensation.	

Lifewise Assurance Life / AD&D Buy-up

Base \$10K Life/AD&D is required on all employees enrolling in the medical plan (except industries in which it is unavailable).

Life enrollment Election: (Must Choose one of the following options):

- Medical Enrollees Only All Eligible

<input checked="" type="checkbox"/> Base \$10K Life / AD&D (required) <input type="checkbox"/> \$20K Life / AD&D (Optional Buy-up)	<input type="checkbox"/> \$30K Life / AD&D (Optional Buy-up)** <input type="checkbox"/> \$40K Life / AD&D (Optional Buy-up)** <input type="checkbox"/> \$50K Life / AD&D (Optional Buy-up)** ** Available only to groups of 10 or more Eligible Employees Enrolling
---	--

Participation/ Eligibility Requirements

Company must enroll at least 2 eligible employees and must meet the definition of a "business group" under Washington state law. All enrolled employees must have a bona fide employee relationship with the Employer. If the employer requires employees to contribute to the employee-only premium, a minimum of 75% of all eligible employees must enroll in the plan. A Refusal of Enrollment / Change / Waiver Form must be submitted for all employees and dependents declining coverage. If employer contributes 100% of the employee premium, 100% of eligible employees must enroll in the plan. The employer must contribute at least 75% of the cost of the employee or 50% of the employee and 50% of the dependent premium. Eligible employees must be full-time employees as defined on page 1 of the application.

Agent Designation

Agent Name: _____ Agency: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Employer Statement

- We wish to enroll our firm as a group account with the Pacific Health Trust. We understand that the Pacific Health Trust is the purchasing group that sponsors this plan, and that medical benefits are underwritten and administered by Health Net of Oregon, a Washington-licensed health care service contractor. Benefits and eligibility provisions are specified in the contract between the Pacific Health Trust and Health Net of Oregon, of which this application forms a part. We also understand that vision benefits are provided by VSP® and VSP® is solely responsible for administration of those benefits.
- We understand the eligibility rules applicable to employee enrollment.
- We understand premiums are prepaid and are due no later than the first day of each month.
- We certify that we have received a fully completed and unaltered Enrollment / Change / Waiver Form from each eligible employee and that we will keep these forms on file in their original state indefinitely. They will be immediately available for use by the Plan Administrator or Carrier.
- We understand an individual's coverage terminates the last day of the month in which employee or dependent ceases to be eligible under eligibility provisions.
- There will be one open enrollment period per contract year 30 days prior to the renewal effective date.
- This Agreement consisting of the Plan Contract/Group Policy as supplemented by the Group Application has been entered into between Pacific Health Trust and the Employer Group in order to provide eligible subscribers and eligible dependents electing to enroll hereunder with the health care benefit as specified in the Plan Contract/Group Policy.

Executed at _____ Date accepted _____
(City, ST)

Signature of Authorized Employer Group Representative

Print Name

Title