

Master Application 2011



OFFICE

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

Medical, RX, Dental and Vision plans offered under 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: _____

Premiums will be paid by: EFT (complete enclosed form) Check (requires additional 2% admin fee)

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

Please note: Federal regulations require you must promptly notify Health Net if the number of employees change from 0-19, 20-99, or 100+.

Since you are part of a multi-employer group health plan, have you obtained a small group employer exception from CMS so that Medicare become primary rather than your health plan, Health Net? Yes No

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 – No Charge (BSI Agreement must be filled out. Form can be found on our website at: www.pacifichealthtrust.com)

Self-Administration

Coverage Applied For (check plans that apply):

Enrollment Packets Needed:

Medical _____ Dental: _____

Does your group fund any portion of the employee/members' deductible through an HRA or other type of funding arrangement? Yes No If Yes, How much do you fund? _____

Health Net Medical Plans

• Groups under 6 choose one plan

• Groups with 6+ enrolled may choose multiple plans (no minimum enrollment per plan)

Health Net RX Plan

Choose one option

VSP Vision Plan

Choose one option

<input type="checkbox"/> PPO 250 (WPT152V2LX) <input type="checkbox"/> PPO 500 (WPT155V2DX) <input type="checkbox"/> PPO 750 (WPT207V2DX) <input type="checkbox"/> PPO 1000 (WA25-1000-2-2500D)	<input type="checkbox"/> Rx \$10 / \$20 / \$40 <input type="checkbox"/> Rx \$15 / \$30 / \$50 <input type="checkbox"/> Rx \$15 / \$35 / \$60 <input type="checkbox"/> Rx \$15 / 30% / 50% - \$5,000 OOP Max <input type="checkbox"/> No Rx	<input type="checkbox"/> VSP \$0 / \$10 <input type="checkbox"/> VSP \$10 / \$25 <input type="checkbox"/> No Vision
<p>Note: Pharmacy & Vision enrollment must match the medical enrollment.</p>		
<p style="text-align: center;"><u>Guardian Dental Plans</u></p>		
<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"/> No Dental		

Optional Benefits:

- Domestic Partner Coverage - No Charge—Select to add benefit only at renewal
- 24 Hour Owner Coverage – No Charge - Attach a list including full names for all owners/officers excluded from Workers Comp.
- Employee Assistance Program through RFL (\$0.54 per employee charge)
- LifeBalance Card (\$.86 per employee charge)

Lifewise Assurance Life / AD&D Buy-up

(Base \$10K Life/AD&D is included on all employees enrolling in the medical plan)

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)** <p style="text-align: center;">** Available to groups of 10 or more eligible employees</p>
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Flexible Spending Account

Election: If yes to any of the below options, please complete and attach the BSI enrollment form. Additional charges apply.

FSA Yes No HRA Yes No

DCAP Yes No HSA Yes No

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. 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.
- We understand that this plan contains a pre-existing conditions exclusion period for enrollees over age 19, which will be reduced by any applicable creditable coverage in accordance with Washington state and federal regulations.
- 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.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

Executed at _____ Date accepted _____
(City, ST)

Signature of Authorized Employer Group Representative

Print Name

Title