RENEWAL APPLICATION 2011

OFFICE USE ONLY
Group Number: _______
Med RL:_______Rx RL:________

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

Renewal Date:______________________

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)

New Enrollment Packets Needed*: HealthNet: ________ Guardian: ___________

*If Packets are needed for Open Enrollment, please contact the TPA Fullfillment Center @ 877-694-8291 or email pht@bsitpa.com

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):

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)*

Health Net Medical Plans	Health Net RX Plan *Choose one option*	VSP Vision Plan *Choose one option*
❑ PPO 250 (WPT152V2LX)	❑ Rx $10 / $20 / $40	❑ VSP $0 / $10
❑ PPO 500 (WPT155V2DX)	❑ Rx $15 / $30 / $50	❑ VSP $10 / $25
❑ PPO 750 (WPT207V2DX)	❑ Rx $15 / $35 / $60	❑ No Vision
❑ PPO 1000 (WA25-1000-2-2500D)	❑ Rx $15 / 30% / 50% - $5,000 OOP Max	
	❑ No Rx	
❑ PPO 1500 (WPT2515V2DX)	*Note: Pharmacy & Vision enrollment must match the medical enrollment.*	
❑ PPO 2500 (WPT3025V2DX)	Guardian Dental Plans	
❑ HDHP 2000 (HD2000 Single/ HD4000 Family – HSA Qualified)	❑ Plan 1000 ($1,000 Max)	
❑ Value 500 (WA20-500-2-2500V)	❑ Plan 1500 ($1,500 Max)	
❑ Value 1000 (WA30-1000-3-3500V)	❑ Plan 2000 ($2,000 Max)	
❑ Value 2000 (WA35-2000-3-3500V)	❑ 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

☑ Base $10K Life / AD&D (required)	❑$30K Life / AD&D (Optional Buy-up) **
❑ $20K Life / AD&D (Optional Buy-up)	❑$40K Life / AD&D (Optional Buy-up)**
	❑ $50K Life / AD&D (Optional Buy-up)**
	** Available to groups of 10 or more eligible employees

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 Statement

I certify that all information contained in this application is correct to the best of my knowledge. I also certify that: This firm is a bona-fide business establishment. All participation requirements have been met. Coverage's, enrollment provisions, eligibility requirement, benefits, limitations, and exclusions have been fully explained and understood by the applicant or employer. Co-payments (if applicable) have been fully explained and understood by the employer. I know of no reason why the Plan coverage should not be offered, and I recommend that such coverage be offered.

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