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|--------|--|
| OFFICE | Group Number: _____ |
| | Med RL: _____ Rx RL: _____ |
| | Trust Fee: <input type="checkbox"/> Attached <input type="checkbox"/> Waived |

Pacific Health Trust Participating Employer Renewal Application

Medical and pharmacy plans offered under Pacific Health Trust are underwritten and administered by Health Net Health Plan of Oregon, Inc. Vision plans are underwritten and administered by VSP®. Life and AD&D coverage are underwritten and administered by LifeWise Assurance Company. Dental plans are underwritten and administered by Guardian Dental.

Company Information

Renewal Date: _____

Association Membership: _____ Member Since: _____

Full Legal Name of Company: _____ Tax ID/EIN: _____

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: _____

Employee Information

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

Please check the appropriate box for total number of employees, including seasonal, part-time and full-time 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 changes from 0-19, 20-99 or 100+.

If you are part of a multi-employer group health plan, has CMS approved a Small Employer Exception for your group?

Yes No

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

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

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

Employer Contribution (must equal 75% or more of Employee Rate or 50% of Employee Rate and 50% of Dependent Rate)

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.

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.

Do you wish to provide benefits for domestic partners? Yes No

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:

AGC 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+ enrollment may choose two plans (<i>minimum of 3 enrolled in each plan</i>) | | Health Net Pharmacy Plans – choose one option | VSP Vision Plans – choose one option |
| <input type="checkbox"/> PPO 50-2500 (\$50/\$0/50%/ \$2,500A) <input type="checkbox"/> PPO 50-5000 (\$50/\$0/50%/ \$5,000A) <input type="checkbox"/> PPO 250 (\$15/\$250/20%/ \$1,000LX) <input type="checkbox"/> PPO 500 (\$15/\$500/20%/ \$1,500DX) <input type="checkbox"/> PPO 750 (\$20/\$750/20%/ \$2,500DX) | <input type="checkbox"/> PPO 1000 (\$25/\$1,000/20%/ \$2,500DX) <input type="checkbox"/> PPO 1500 (\$25/\$1,500/20%/ \$2,500DX) <input type="checkbox"/> PPO 2500 (\$30/\$2,500/20%/ \$2,500DX) <input type="checkbox"/> PPO 3000 (\$30/\$3,000/20%/ \$9,000DX) | <input type="checkbox"/> Rx \$10 / \$20 / \$40 <input type="checkbox"/> Rx \$10 / \$50 / \$75 <input type="checkbox"/> Rx \$15 / \$30 / \$50 <input type="checkbox"/> Rx \$15 / 30% / 50% \$5000M <input type="checkbox"/> No Rx | <input type="checkbox"/> VSP \$0 / \$10 <input type="checkbox"/> VSP \$10 / \$25 <input type="checkbox"/> No Vision |
| Health Net Medical High Deductible Health Plan <input type="checkbox"/> HDHP 1500 (\$1,500 / 20% / \$3,000 w/ 20% Rx) | | <i>Note: Vision and pharmacy 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) * Orthodontia coverage is only available to groups of 10+ eligible employees. | | Optional Benefits <input type="checkbox"/> COBRA Administration through BenefitHelp Solutions (\$1.76 per employee charge) <input type="checkbox"/> Employee Assistance Program through RFL (\$.075 per employee charge) <input type="checkbox"/> LifeBalance Card (\$1.00 per employee charge) <input type="checkbox"/> Domestic Partner Coverage (No charge – Select to Add Benefits) <input type="checkbox"/> 24-Hr. Coverage Provide Full Name of Owner(s): _____ | |
| Lifewise Assurance Life / AD&D Buy-up Life enrollment Election (must choose one of the following options): <input type="checkbox"/> Medical Enrollees Only <input type="checkbox"/> All Eligible | | | |
| <input checked="" type="checkbox"/> Base \$10K Life / AD&D (included on all employees enrolling in the medical plan) <input type="checkbox"/> Additional \$20K Life / AD&D (Optional Buy-up) <input type="checkbox"/> Additional \$30K Life / AD&D (Optional Buy-up) <input type="checkbox"/> Additional \$40K Life / AD&D (Optional Buy-up) <input type="checkbox"/> Additional \$50K Life / AD&D (Optional Buy-up) | | | |

Participation/ Eligibility Requirements

Company must employ at least 2 eligible employees for enrollment 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 Coverage/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 coverage. Eligible employees must be full-time employees as defined on page 1 of the application.

Agent Designation

A business applying for insurance coverage through Pacific Health Trust may appoint their own agents to represent them in arranging insurance coverage. This agreement will serve as notice of cancellation of any previous agent agreement. This new appointment will remain in effect until written notice is given by either party. No changed may be made retroactively. The applicant hereby appoints the below named agent as the firm's agent of record:

Agent Name: _____ Signature: _____
 Agency: _____
 Address: _____
 City: _____ ST: _____ ZIP: _____
 Phone: _____ Fax: _____ Email: _____

Employer Statement

- We wish to enroll our firm as a group account with Pacific Health Trust. We understand that Pacific Health Trust is the purchasing group that sponsors this plan, and that medical benefits are underwritten and administered by Health Net Health Plan of Oregon, Inc., a Washington-licensed health care service contractor. Benefits and eligibility provisions are specified in the contract between Pacific Health Trust and Health Net, of which this Participating Employer application forms a part. We understand that vision benefits are provided by VSP® respectively, and they are solely responsible for administration of those benefits. We understand that life and AD&D benefits are provided by LifeWise Assurance Company respectively, and they are solely responsible for administration of those benefits. We understand that dental benefits are provided by Guardian Dental respectively, and they are solely responsible for administration of those benefits.
- We understand the eligibility and participation 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 and Change Application from each participating 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 insurance company.
- We understand an individual's coverage terminates the last day of the month in which an employee or dependent ceases to be eligible under group 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/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, State)

Signature of Authorized Employer Group Representative _____ Print Name _____ Title _____