

# Small Group Master Application – Montana

For groups of 1-50 employees



## Employer information

Legal name of group \_\_\_\_\_ Effective date \_\_\_\_\_  
DBA name (appears on bills and ID cards) \_\_\_\_\_ SIC or NAICS code \_\_\_\_\_  
Physical address required (no PO box) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_  
Mailing address (if different than physical address) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_  
Federal Tax ID No. \_\_\_\_\_ Company headquarters state \_\_\_\_\_ Nature of business \_\_\_\_\_  
Name(s) of all owners and partners \_\_\_\_\_

### Form of organization (check all that apply)

Limited liability company  
Sole proprietorship  
Subchapter S-corp  
Government  
Partnership  
Association  
Nonprofit  
MEWA  
Union  
C-corp  
Church  
Trust

## Group contacts

Group contact \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_  
Billing contact \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_

## Affiliates (to add more contacts, please attach additional pages)

Is your company affiliated with any other? Yes No Will it be insured with PacificSource? Yes, Common Ownership Form is attached No  
Name of affiliate(s) \_\_\_\_\_ No. of employees \_\_\_\_\_  
Address of affiliate(s) \_\_\_\_\_ Should each affiliate be billed separately? Yes No

## Current insurance (required if you had prior coverage)

**Medical**  
Carrier \_\_\_\_\_  
Policy no. \_\_\_\_\_  
Term date \_\_\_\_\_

**Dental**  
Carrier \_\_\_\_\_  
Policy no. \_\_\_\_\_  
Term date \_\_\_\_\_  
Who was eligible for your prior dental plan?  
Children only      Adults and children

**Existing workers' compensation**  
Carrier \_\_\_\_\_  
Policy no. \_\_\_\_\_

## Medical benefit information

The medical policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the ACA for small groups. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Contact your broker or let your PacificSource representative know if you wish to purchase a stand-alone dental care product.

Please select no more than four plans for your group members to choose from. Need some guidance? Please contact your sales representative with questions.

### Navigator

Platinum 500	Gold 3000	Silver 5500	Silver HSA 5500
Platinum 500 VH	Gold 3000 VH	Silver 5500 VH	Bronze 7500
Gold 1000	Gold HSA 3400	Silver 6500	Bronze 9200
Gold 1000 VH	Silver 3000	Silver 6500 VH	Bronze 9200 VH
Gold 2000	Silver 4500	Silver HSA 3500	Bronze HSA 8050
Gold 2000 VH	Silver 4500 VH	Silver HSA 5100	

## Dental Benefit Information

Dental Choice Core	Dental Choice Plus 0-20-50 25-1000	Kids Dental Choice 0-20-50 (coverage for members age 18 and younger)
Dental Choice 0-20-50 750	Dental Choice Plus 0-20-50 25-1500	Kids Dental Choice 20-40-50 (coverage for members age 18 and younger)
Dental Choice 0-20-50 1000	Dental Choice Plus 0-20-50 50-1000	
Dental Choice 0-20-50 1500	Dental Choice Plus 0-20-50 50-1500	

## Billing structure

**Billing structure (check one):**    Age banded rates (based on age)      Tiered rates (based on family composition)

## Employer premium contribution (the amount the employer will contribute toward the employee and dependent premium)

**Medical:** % \$ Employee \_\_\_\_\_ Dependent \_\_\_\_\_

**Dental:** % \$ Employee \_\_\_\_\_ Dependent \_\_\_\_\_

## Eligibility

### Probationary waiting period

Date of hire (premium prorated first month)

First of the month following date of hire

First of the month following 30 days

First of the month following 60 days

90 calendar days effective on 91st calendar day (premium prorated first month)

Other \_\_\_\_\_

### If the last day of the probationary period falls on the first day of the month, when will the new employee's eligibility be effective?

Eligible that day

Must wait until the first day of the following month or 91st day, whichever comes first (default if not marked)

**Initial enrollment: Will the probationary period be waived at initial enrollment?** Yes No

### Minimum hours

How many hours per week must employees work to be eligible for coverage?

Hours per week \_\_\_\_\_

### Eligible members

Plan covers:

Employee + spouse/domestic partner + children

Employee only

## HSA, HRA, FSA, COBRA administration, EAP, or POP

Check accounts your group has HSA HRA FSA COBRA administration EAP POP

If your accounts include COBRA administration, is your COBRA administered by PacificSource Administrators, Inc.? Yes No

If your COBRA account is not administered by PacificSource Administrators, should COBRA members be on a separate bill from employees? Yes No

Billing should be sent to: Employer group Third-party administrator

Employer contribution to HRA or HSA \_\_\_\_\_

Third-party administrator name \_\_\_\_\_ Phone \_\_\_\_\_

Mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

## People to be insured

1. \_\_\_\_\_ Total number of employees (full-time, part-time, owner, partner, principal, probationary, and waiver; exclude continuation)
2. \_\_\_\_\_ Total number of former employees currently on continuation or retiree coverage with your group health plan (submit Employee Enrollment and Waiver Form)

**A. \_\_\_\_\_ TOTAL number of EMPLOYEES: Add numbers 1 and 2 above**

3. \_\_\_\_\_ Total number of employees who do not qualify due to hourly requirement
4. \_\_\_\_\_ Total number of employees who do not qualify due to waiting period requirement
5. \_\_\_\_\_ Total number of employees waiving coverage due to other qualified coverage\* (submit Employee Enrollment and Waiver Form)

\*Qualified coverage: Employer Plan, Medicare, Medicaid, VA/Tricare, and Indian Health Service

6. \_\_\_\_\_ Total number of employees not insured for reasons not stated above

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

**B. \_\_\_\_\_ TOTAL number of EMPLOYEES NOT ENROLLING: Add numbers 3 through 6 above**

**C. \_\_\_\_\_ TOTAL number of EMPLOYEES ENROLLING, including continuation: Subtract B from A above**

**SERVICE AREA:** Do all employees reside within the PacificSource service area?    Yes    No    If no, what state(s): \_\_\_\_\_

**ERISA:** Is your group composed of employees of a government entity or church that is NOT subject to ERISA?    Yes    No

**Medicare coordination (TEFRA):** Did you employ 20 or more employees each working day each of 20 or more calendar weeks in the **current or preceding calendar year**?    Yes    No

**COBRA:** Did you employ 20 or more total employees (full-time, part-time, seasonal) at least 50% of your business days **in the preceding calendar year**?  
Yes    No

**Employees on continuation of coverage (COBRA or USERRA):**

Are any enrolling members covered under continuation on this plan?    Yes    No

If yes, Employee Enrollment and Waiver Form must be submitted for each employee on continuation.

**RETIREE:** Is group coverage available to retirees?    Yes    No

Is the group a local government (school, city, county)?    Yes    No

*Approval is dependent on PacificSource policy and approval. If you offer health or dental coverage to your retirees, please attach the requirements and employer premium contribution if any.*

## Requirements—must be submitted prior to policy effective date

- Group Master Application
- Copy of sold rates
- Member employee enrollment and waiver information
- Binder payment (estimated first month premium) *Refunded if coverage not effectuated*
- Electronic Funds Transfer Form, optional
- Common Ownership Form, if applicable
- Group Identification Form, if applicable

This is an application for group insurance. Under no circumstances will coverage be in force until the policy is issued by PacificSource and accepted by the employer. Once a policy is issued, the policy terms control in all cases.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

**If you type your name below, you understand that you are electronically signing this document and agree your electronic signature is the legal equivalent of your manual signature on this application.**

**Group representative (printed)** \_\_\_\_\_ **Title** \_\_\_\_\_

**Group representative signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I, the undersigned producer for this group, affirm that the information provided on this application is complete and correct to the best of my knowledge.

**Producer name (printed)** \_\_\_\_\_ **PacificSource producer no.** \_\_\_\_\_

**Producer signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### What happens next?

1. You'll get an email with information to help you administer the plan.
2. You'll get the contract and a handbook in the mail.
3. We'll send your employees their ID cards.

**If additional information is needed, a PacificSource representative will contact you. Please keep a copy of this application for your records.**

## Discrimination is Against the Law

PacificSource Health Plans (“PacificSource”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PacificSource:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 888-977-9299.

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, 888-977-9299, TTY 711, Fax 541-684-5264, or email [CRC@PacificSource.com](mailto:CRC@PacificSource.com). Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
 200 Independence Avenue, SW  
 Room 509F, HHH Building  
 Washington, D.C. 20201  
 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Amharic	<p>ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የPacificSource Health Plans ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀናችን ፈልጎ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። (888) 977-9299 ይደውሉ።</p>
Arabic	<p>يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال PacificSource Health Plans. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك (888) 9299-977 من دون أي تكلفة. اتصل بـ</p>



Korean	<p>본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 PacificSource Health Plans 을 통한 커버리지 에 관한 정보를 포함하고 있습니다.</p> <p>본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 리가 있습니다. (888) 977-9299 로 전화하십시오.</p>
Laotian	<p>ການແຈ້ງການນີ້ ມີຂໍ້ ມູ ນໍ້ສາຄໍ ນ. ການແຈ້ງການນີ້ ມີຂໍ້ ມູ ນໍ້ສາຄໍ ນກໍ່ ງອກ ບໍ່ຄາຍ້ ອງສະໜັ ກຫ ັ້ ການຄໍ ມ ອອງຂອງທ່ ານໂດຍຜ່ ານ PacificSource Health Plans. ຕື່ ບ່ງສາຄໍ ບກໍ່ ານ ດວ້ ນທ ັ້ ສາຄໍ ນໃນແຈ້ ງການນີ້ . ທ່ ານອາດຈາເບ້ ນຕໍ່ ອງໃຊ້ ເວລາອໍ ດາເນນການໂດຍກໍ່ ານ ດເວລາອໍ ດາເນນ ນອນ ຈະ ຮັ ກສາການຄໍ ມອອງສຂະພາບຂອງທ່ ານຫ ັ້ ການຊ່ ວຍເຫ ັ້ ອໍ ທມຄໍ າໃຊ້ ຈ່ າຍ. ທ່ ານມັສດທຈະໄດ້ ຮັ ບໍ່ຂໍ້ ມູ ນ ຂ່ າວສານນີ້ ແລະການຊ່ ວຍເຫ ັ້ ອໃນພາສາຂອງທ່ ານທໍ່ ບມຄໍ າໃຊ້ ຈ່ າຍ. ໂທ (888) 977-9299.</p>
Nepali	<p>यो स चनामाा महत्त्वप र्ु जानकारी छ । यो स चनामाा तपाईंको ो आवेिन वा PacificSource Health Plans का माध्यमबाट प्राप्त हुने सद्ु विबारे महत्त्वपर्ु जानकारी छ । यो सचू नामा भएका महत्त्वपर्ु दमदतहरू ख्याल िनुहु ोस् । तपाईंले पाइरहके ो स्वास्थ्य दबमा पाइरहन वा तपाईंको खचुको भक्तानीमाुसहायता पाउन के ही समयकारवाही िन -सीमामा काम-ुपनु हनसक्छु । तपाईंले यो जानकारी र सहायता आफ्नो मातभृ ाषामा दन शल्ु क पाउनु तपाईंको अदिकारः हो (888) 977-9299 मा फोन िनुहु ोस् ।</p>
Norwegian	<p>Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom PacificSource Health Plans. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helse-dekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt spark uten kostnad. Ring (888) 977-9299.</p>
Pennsylvania Dutch	<p>Die Bekanntmachung gebt wichdichi Auskunft. Die Bekanntmachung gebt wichdichi Auskunft baut dei Application oder Coverage mit PacificSource Health Plans. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimnde Deadlines, so ass du dei Health Coverage bhalde kansch, odder bezaahle helfe kansch. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kansch du (888) 977-9299 uffrufe</p>
Persian	<p>این اعلامیه حامی اطلاعات مهم میباشد. این اعلامیه حامی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما مربوط به PacificSource Health Plans به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است تا به تاریخ های مشخصی برای حفظ پوشش مزایای یا برای کمک به مخارج مزایای ملزوم به انجام کارهایی شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید (888) 977-9299</p>
Punjabi	<p>ਇਸ ਨੇ ਜਿਸ ਜਵਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੇ ਜਿਸ ਜਵਚ PacificSource Health Plans ਵਲੋਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਿਾਰੇ ਮਹਿੰ ਤਵਪ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੇ ਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱ ਚ ਮਦਦ ਦੇ ਇਛੁਿੱ ਕ ਹੋ ਤਾਂ ਤੁਹਾਨ ੂੰ ਆ ਤਮ ਤਾਜਰਖ ਤੋ ਪਜਹਲਾਂ ਕੁਿੱ ਝ ਖਾਸ ਕਦਮ ਚੁਿੱ ਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨ ੂੰ ਮੁਫਤ ਜਵਚ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱ ਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਕਾਲ (888) 977-9299</p>
Romanian	<p>Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin PacificSource Health Plans. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la (888) 977-9299.</p>



Russian	Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через PacificSource Health Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (888) 977-9299.
Serbo-Croatian	U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko PacificSource Health Plans. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određene radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite (888) 977-9299.
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de PacificSource Health Plans. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (888) 977-9299.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng PacificSource Health Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (888) 977-9299.
Thai	ประกาศนี้มีข้อมูลสำคัญประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอขอบเขตประกันสุขภาพของคุณผ่าน PacificSource Health Plans ดูกำหนดการในประกาศนี้คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่ายโทร (888) 977-9299.
Ukrainian	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страховального покриття через PacificSource Health Plans. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону (888) 977-9299.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin nộp hoặc hợp đồng bảo hiểm qua chương trình PacificSource Health Plans. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình hoàn toàn miễn phí. Xin gọi số (888) 977-9299.