EMPLOYER ENROLLMENT APPLICATION

CHECK APPLICABLE BOX: ☐ **NEW ENROLLMENT** ☐ **CHANGE**

REQUESTED EFFECTIVE DATE __ __ / __ __ / __ __ __ __

Are you affiliated with an association or chamber? ☐ Yes ☐ No Name of association or chamber________________

GENERAL INFORMATION

Exact legal name of company

Doing business as (DBA)

Business description

Choose standard industrial classification (SIC):

☐ Agriculture ☐ Forestry ☐ Fishing ☐ Mining ☐ Construction ☐ Manufacturing ☐ Transportation ☐ Communications ☐ Electrical ☐ Gas ☐ Sanitary Services ☐ Wholesale Trade ☐ Retail Trade ☐ Finance ☐ Insurance ☐ Real Estate ☐ Services ☐ Public Administration

Employer's Federal tax ID number

Physical street address

Suite City

State Zip –

Mailing/billing address

Suite City

State Zip –

Company phone number / / Extension Company fax number / /

How would you like to receive correspondence from PacAdvantage?

☐ Mail ☐ Fax ☐ E-mail (E-address)

Saluation

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other ________________

Authorized representative M.I. Designated contact's last name (Suffix Jr., Sr., etc.)

Alternate contact's first name M.I. Alternate contact's last name (Suffix Jr., Sr., etc.)

PacAdvantage
Choice • Simplicity • Affordability

Mode of payment ☐ **CHECK** ☐ **EFT**

ELECTRONIC FUNDS TRANSFER ELECTION FORM (EFT)

If you would like to take advantage of the convenience of having your premium automatically deducted from your bank account each month, please complete and return with the Employer Application. If submitting separately:

Mail to 3013 Douglas Blvd., Suite 200, Roseville, CA 95661 or Fax to 916-786-6905

I authorize PacAdvantage to initiate debit transactions to the bank account indicated below for the payment of my monthly insurance premiums. I understand that:

- **My account will be debited on the last business day before the due date.**
- **Bank account changes must be reported at least 15 days prior to the withdrawal date.**
- **I will continue to receive an itemized invoice each month for my records.**

Group Number ___ ___ ___ ___ ___ ___ ___ ☐ Start EFT ☐ Change

Name on bank account

___ ___

Bank name

___ ___

Account type ☐ Checking ☐ Savings

Bank Routing (ACH) number ___ ___ ___ ___ ___ ___ ___ ___ ___

Bank account number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Signature: ______________________________

PLEASE INCLUDE A COPY OF A VOIDED CHECK

MR. & MRS. JOHN DOE
SOME CITY IN THE US
UNITED STATES OF AMERICA 00000

MISCELLANEOUS BANK
UNITED STATES

00-0000-0/00

CHECK NO.
0000

PAY TO
THE ORDER OF

DATE ______________

______________________________ 00/100

MEMO ______________ ______________
AUTHORIZED SIGNATURE

⑆ 1 2 3 4 5 6 7 8 9 ⑆ 0 1 2 3 4 5 6 7 8 9 ⑈ 4 5 6

ROUTING NO. (ABA)
Always 9 digits and to the left of the account number

ACCOUNT NO.
Number of digits varies

CHECK NO.
Sometimes to the left of the account number

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AGENT INFORMATION

Agent/Broker must complete the **Agent of Record** and **Writing Agent** sections to receive proper credit. The Agent(s) of Record will receive fees. Agencies or corporations will not be accepted as a Writing Agent. All correspondence, including Open Enrollment materials, will be sent to the Writing Agent. Please fill out any name information as it appears on your California license.

AGENT OF RECORD 1

Last name/Agency name/General agency name ___ First name ___ M.I. ___

Agent's license number ___ Commission split percentage ___ - ___ % PacAdvantage agent number ___

AGENT OF RECORD 2

Last name/Agency name/General agency name ___ First name ___ M.I. ___

Agent's license number ___ Commission split percentage ___ - ___ % PacAdvantage agent number ___

WRITING AGENT

Last name ___ First name ___ M.I. ___

Agent's license number ___ PacAdvantage agent number ___

I, the Writing Agent, certify that I have met with the employer submitting this application and that I have fully explained the contents of the application. I have discussed coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions.

SIGNATURE OF WRITING AGENT

Signature ___ Date signed ___ / ___ / ___

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CONTRIBUTION STRATEGY WORKSHEET

Minimum employer contribution per employee is 50% of the average of the group's premium for all enrolled employees based on the lowest available employee-only rate.

A. MEDICAL
Choose one

Employer will pay:

_______ % of the lowest cost HMO plan for each employee and _______ % for dependent coverage.

_______ % of the lowest cost plan for the employee and _______ % for dependent coverage.

A dollar amount of $ _______ for each employee and $ _______ for dependent coverage.

_______ % of a specified plan for each employee and _______ % for dependent coverage.

name of specified plan ____________________

Current group insurer (if any) ____________________

B. DENTAL
Are you electing coverage through PacAdvantage? ☐ Yes ☐ No

Choose one

Employer will pay:

_______ % of the lowest cost HMO plan for each employee and _______ % for dependent coverage.

_______ % of the lowest cost plan for the employee and _______ % for dependent coverage.

A dollar amount of $ _______ for each employee and $ _______ for dependent coverage.

_______ % of a specified plan for each employee and _______ % for dependent coverage.

name of specified plan ____________________

Current group insurer (if any) ____________________

C. VISION
Are you electing coverage through PacAdvantage? ☐ Yes ☐ No

Choose one

Employer will pay:

_______ % of the lowest cost HMO plan for each employee and _______ % for dependent coverage.

_______ % of the lowest cost plan for the employee and _______ % for dependent coverage.

A dollar amount of $ _______ for each employee and $ _______ for dependent coverage.

_______ % of a specified plan for each employee and _______ % for dependent coverage.

name of specified plan ____________________

Current group insurer (if any) ____________________

D. CHIROPRACTIC/ACUPUNCTURE
Are you electing coverage through PacAdvantage? ☐ Yes ☐ No

Choose one

Employer will pay:

_______ % of the lowest cost HMO plan for each employee and _______ % for dependent coverage.

_______ % of the lowest cost plan for the employee and _______ % for dependent coverage.

A dollar amount of $ _______ for each employee and $ _______ for dependent coverage.

_______ % of a specified plan for each employee and _______ % for dependent coverage.

name of specified plan ____________________

Current group insurer (if any) ____________________

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COVERAGE INFORMATION

New employee waiting period

☐ None ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Day ☐ Other ___ ___ ___

If selecting multiple waiting periods, indicate employee classification and waiting period

Managerial	___ ___	Days	Exempt	___ ___	Days	Union	___ ___	Days	Full-time	___ ___	Days	
Non-Managerial	___ ___	Days	Non-Exempt	___ ___	Days	Non-Union	___ ___	Days	Part-time	___ ___	Days	(if applicable)

Are you legally required to provide workers' compensation coverage for your employees?

☐ Yes ☐ No If not, please specify reason: ________________________________

Workers' compensation carrier name ___

Prior medical plan coverage ___

Employee census

NOTE: Part-time employees work 20-29 hours per week; full-time employees work at least 30 hours per week.

How many employees (full-time and part-time)?

___ ___ ___

How many full-time employees at time of application?

___ ___ ___

How many eligible employees at time of application?

___ ___ ___

How many eligible employees apply for coverage?

___ ___ ___

Include with your submission your most recent DE3B, DE6, or DE3DP. A Federal W-4 or payroll records are required for any employee not listed on the quarterly wage and tax statement. We must know the status of each employee listed: part-time (PT), terminated (T), waiving (W), declining (D), or enrolling (E).

Have you employed 20 or more employees for 20 or more weeks during the current or preceding year? (TEFRA)

☐ Yes ☐ No

Have you employed 20 or more full-time or part-time employees during at least 50% of the preceding calendar year? (COBRA)

☐ Yes ☐ No

Would you like to offer coverage to permanent part-time (20-29 Hours per week) employees?

☐ Yes ☐ No

Would you like to offer coverage to domestic partners?

☐ Yes ☐ No

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DECLARATIONS

Please read the following carefully and sign below.

- Every potentially eligible employee has been informed of the opportunity to obtain coverage through PacAdvantage,.
- The employer will abide by the rules of participation and premium payment requirements of the Program.
- One hundred percent of the eligible employees enrolling in the Program who are legally required to be covered by Workers' Compensation insurance are so covered.
- Each employee applying for enrollment in the Program is an eligible employee under the rules of the Program.
- If purchasing dental, vision, or complementary medicine insurance, 100% of the employees who have enrolled in health insurance must be enrolled in dental, vision, or complementary medicine except for dependents under age two (2). If an employee has waived health insurance and elects to enroll in any optional benefits, the employee must enroll for all optional benefits offered by the employer.
- The employer will contribute an amount equal to at least 50% of the average of the group's premium for all enrolled employees based on the lowest available employee-only rate.
- At least 70% of the eligible employees are applying for enrollment. If this employer elects to contribute 100% of the employee-only premium, 100% of the eligible employees must enroll in the Program. If there are only two (2) or three (3) eligible employees, 100% of the eligible employees must enroll.
- When an eligible employee or dependent ceases to be eligible, the employer will inform the Program by the end of the month in which the event occurs.
- All eligible employees who have declined/waived medical coverage in the Program for themselves or any of their dependents have signed a form explaining to them the limitations on future enrollment in the Program. This employer agrees to maintain copies of the signed forms declining/ waiving coverage for a period of one year.
- Program rules require every individual to furnish complete and accurate information for application to the Program. Failure to furnish this information may result in the return of the application as incomplete.
- The employer shall notify the Program of an employee who becomes eligible for COBRA or Cal-COBRA within 30 days of the qualifying event. Cal-COBRA employers with fewer than 20 employees shall notify the Program within 30 days of the date the employer becomes subject to COBRA.

ARBITRATION NOTICE

Pacific Health Advantage is a purchasing cooperative offering a variety of health/dental/vision/complimentary medicine options. Enrollment in many of the plans constitutes an agreement to have any dispute decided by binding arbitration and waiver of any right to a jury or court trial. Refer to the plan's Evidence of Coverage or Certificate of Insurance to determine whether the plan(s) you have selected require binding arbitration. **If you choose a medical, dental, vision, or complementary medicine plan which requires resolution of disputes through binding arbitration, you, your dependents, and the plan are waiving any right to a jury or court trial.**

SIGNATURE OF AUTHORIZED REPRESENTATIVE

As the legally authorized representative of the employer, I certify that I have read and understand the above declarations and that all the information provided to apply for the Program is accurate and complete to the best of my knowledge.

Signature ______________________________ Date signed __ __ / __ __ / __ __ __ __