EMPLOYER REQUALIFICATION FORM

Group number ___ ___ ___ ___ ___ ___ ___

Exact legal name of company_______________

Doing business as (DBA) _______________

Employers' federal tax ID number _______________

GENERAL INFORMATION

Designated contact name _______________

Location address

Street _______________

Suite _______________

City _______________

State _______________ Zip _______________

Mailing address

Street _______________

Suite _______________

City _______________

State _______________ Zip _______________

Company phone number ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Company fax number ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Email address _______________

COVERAGE INFORMATION

New employee waiting period

☐ None ☐ 30 days ☐ 60days ☐ 90 days ☐ 180 days ☐ 365 days ☐ Other ___ ___ ___

EMPLOYER CONTRIBUTION OPTIONS	MEDICAL		DENTAL (IF APPLICABLE)		VISION (IF APPLICABLE)		CAM (IF APPLICABLE)	
	EE	DEP	EE	DEP	EE	DEP	EE	DEP
Percentage (%) of lowet cost HMO plan	%	%						
Flat dollar ($) amount	$	$	$	$	$	$	$	$
Percentage (%) of premium for a specified plan	%	%	%	%	%	%	%	%
Specified plan								
Percentage (%) of lowest cost plan	%	%	%	%	%	%	%	%

EMPLOYEE COUNTS

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 applying for coverage?

___ ___ ___

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

☐ Yes ☐ No

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

☐ Yes ☐ No

PacAdvantage

EMPLOYER REQUALIFICATION FORM

GROUP NUMBER

___ ___ ___ ___ ___ ___ ___

PART-TIME EMPLOYEES AND DOMESTIC PARTNERS

Do you currently or would you like to offer coverage to permanent part-time (20-29 hours per week) employees?

☐ Yes ☐ No

Do you currently or would you like to offer coverage to domestic partners?

☐ Yes ☐ No

ADDITIONAL BENEFITS

(REQUIRES AN EMPLOYEE/MEMBER OPEN ENROLLMENT CHANGE FORM FOR EACH EMPLOYEE ENROLLED IN MEDICAL BENEFITS)

1. Please indicate the optional benefits your group would like to add through PacAdvantage.
   (An employee/member open enrollment change form is required for each employee currently enrolled in medical.)

   ☐ Dental
   Name of current group dental insurer, if any ________________________________

   ☐ Vision
   Name of current group vision insurer, if any ________________________________

   ☐ Chiropractic/acupuncture
   Name of current group chiropractic/acupuncture insurer, if any ________________________

2. Please indicate the optional benefit your group would like to discontinue through Pacadvantage upon your group's requalification date.

   ☐ Dental ☐ Vision ☐ Chiropractic/acupuncture

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.
- The employer represents that other than its contribution towards PacAdvantage coverage, the employer will not and does not offer any employer-funded health benefit, including but not limited to a Health Reimbursement Arrangement (HRA) or health Flexible Spending Account (FSA) under a Section 125 plan funded all or in part by employer dollars, except that an employer may offer an Archer Medical Savings Account (MSA).

SIGNATURE OF EMPLOYER OR EMPLOYER'S AUTHORIZED REPRESENTATIVE

Signature ________________________________ Date signed ___ ___ / ___ ___ / ___ ___ ___ ___