



EMPLOYER ENROLLMENT APPLICATION

(PACADVANTAGE POOL ONLY)

CHECK APPLICABLE BOX: NEW ENROLLMENT CHANGE

REQUESTED EFFECTIVE DATE ____ / ____ / ____

PacAdvantage

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

A. 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) _____

Salutation

- 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

Mode of payment

CHECK

EFT

B. 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 2901 Douglas Blvd., Suite 305, 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 _____		
MEMO _____	AUTHORIZED SIGNATURE _____		00/100
⑆ 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

EMPLOYER ENROLLMENT APPLICATION

C. 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.

D. AGENT OF RECORD 1 (COMMISSION PAID TO AGENT OF RECORD)

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

Agent's license number _____ Commission split percentage _____ % PacAdvantage agent number _____

E. 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 _____

F. WRITING AGENT (ALL CORRESPONDENCE MAILED TO 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. Furthermore, I certify that:

1. I hold a valid Life, Accident & Health License issued in California.
2. This employer is a bona fide business establishment and I believe that participation requirements are being met.
3. I have advised my client not to terminate existing coverage until receiving notice that this coverage being applied for is approved.
4. Coverages, eligibility provisions, waiting periods, and limitations have been fully explained to, and understood by the Employer identified in this document.
5. I have no right to bind, modify, or alter provisions of this program.
6. I will not sell now or in the future any type of product offered through PacAdvantage with an employer wraparound fund. I understand that if I offer such products with an employer wraparound fund, no commission will be paid to me or to any other brokers of record listed on this application and I and any other brokers of record listed on this application will risk termination as a producer for existing and new PacAdvantage business.

G. SIGNATURE OF WRITING AGENT

Signature _____ Date signed _____ / _____ / _____

EMPLOYER ENROLLMENT APPLICATION

H. 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) _____

EMPLOYER ENROLLMENT APPLICATION

I. COVERAGE INFORMATION

New employee waiting period

None 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

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

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

EMPLOYER ENROLLMENT APPLICATION

J. 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 no later than 15 days after the qualifying event. Cal-COBRA employers with fewer than 20 employees shall notify the Program within 15 days of the date the employer becomes subject to COBRA.
- The employer represents that other than its contribution toward PacAdvantage coverage, the employer will not offer any employer-funded health benefits, 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 a Health Savings Account (HSA)

K. ARBITRATION NOTICE

Pacific Health Advantage is a purchasing cooperative offering a variety of health/dental/vision/complementary 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. Such disputes could include medical malpractice and other claims related to the delivery of health services. 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.**

L. 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 ____ / ____ / ____