Bar 7, LLC

BENEFIT ELECTION FORM

I _____ have elected to enroll/waive the following benefits offered by Bar 7, LLC.

MEDICAL PLAN
PacificSource

Monthly Employee Premium

- ☐ **Enroll – Employee Only** — **See Attached Rate Sheet**
- ☐ **Enroll – Employee & Spouse**
- ☐ **Enroll – Employee & Child(ren)**
- ☐ **Enroll – Family**
- ☐ **WAIVE**

Complete PacificSource Enrollment Form

DENTAL PLAN
Delta Dental of Idaho

	Monthly Employee Premium
☐ **Enroll – Employee Only**	**Paid 100% by Employer**
☐ **Enroll – Employee & Spouse**	**$36.18**
☐ **Enroll - Employee & Child**	**$32.07**
☐ **Enroll – Employee & Children**	**$48.72**
☐ **Enroll – Family**	**$82.42**
☐ **WAIVE**	

Complete Delta Dental of Idaho Enrollment Form

I understand that these elections will be effective on the first of the month following 60 days following my date of hire and are considered unchangeable until the end of the benefit plan year unless I have a qualifying change in status.

I also understand that I have access to all Plan Documents & ERISA Compliance Notices by requesting them from my employer.

By signing, I authorize the premiums elected above to be deducted from my paycheck.

Signature:_____ **Date:**_____

HUB

Bar 7, LLC Rates

Effective July 1, 2019—June 30, 2020

Bar 7, LLC will contribute 50% of the Employee Only cost of the medical plan and 100% of the Employee Only cost of the dental plan.

Employees will be responsible for the cost of dependent coverage.

BrightIdea Silver 4000 Medical Rates					
Age	Rate	Age	Rate	Age	Rate
0-14	$183.00	31	$277.00	48	$391.00
15	$199.00	32	$283.00	49	$407.00
16	$205.00	33	$286.00	50	$427.00
17	$211.00	34	$290.00	51	$445.00
18	$218.00	35	$292.00	52	$466.00
19	$225.00	36	$294.00	53	$487.00
20	$232.00	37	$296.00	54	$510.00
21	$239.00	38	$298.00	55	$533.00
22	$239.00	39	$301.00	56	$557.00
23	$239.00	40	$305.00	57	$582.00
24	$239.00	41	$311.00	58	$609.00
25	$240.00	42	$316.00	59	$622.00
26	$245.00	43	$324.00	60	$648.00
27	$250.00	44	$334.00	61	$671.00
28	$260.00	45	$345.00	62	$686.00
29	$267.00	46	$358.00	63	$705.00
30	$271.00	47	$373.00	64+	$717.00

Delta Dental of Idaho PPO 50 Dental Rates	
Coverage Tier	Rate
Employee	Paid by 100% Employer
Employee & Spouse	$36.19
Employee & Child	$32.07
Employee & children	$48.72
Family	$82.42

PacificSource HEALTH PLANS

Enrollment Application and Waiver of Coverage
Idaho

This area to be completed by group administrator and must be completed prior to submission.

Group Policy No. GE000517 Subgroup No. _____ Class No. or Plan _____

Section 1: Enrollment Information

Employer/Group Name Bar 7, LLC Effective Date (MM-DD-YY) _____

Date of Full-time Hire (required) (MM-DD-YY) _____ No. Hours Worked per Week _____ Are you an owner of this company? ☐ Yes ○ No

Section 2: Employee Information

Last Name _____

First Name _____ MI _____

Mailing Address _____

City _____ State _____ ZIP _____

Daytime Phone _____

Email _____

Marital Status: ☐ Single ○ Married ○ Domestic Partnership Race/Ethnicity* _____

Gender: ○ Male ○ Female Birth Date (MM-DD-YY) _____

Social Security No. _____

Enrollment Due to:

☐ New Group
○ Open Enrollment
○ New Hire
○ Adding Dependent(s)
○ Involuntary Loss of Other Group Coverage

Date of Qualifying Event:

_____
(Attach proof of event)

Eligible for COBRA Due to:

☐ Employment Termination or Reduced Hours
○ Divorce or Legal Separation
○ Death of Employee
○ Dependent No Longer Meets Eligibility

Date of Qualifying Event:

_____
(Attach proof of event)

Primary Care Provider** _____

Are you enrolling in PacificSource medical coverage? ☐ Yes ○ No ~~Are you enrolling in PacificSource dental coverage?~~ ☐ Yes ○ No

If you are declining coverage then skip to section 5.

Are you, your spouse, domestic partner or any of your dependents listed on this application currently disabled? ○ Yes ○ No

Name of Disabled Person _____ Date of Disability _____

Nature of Disability _____

* Race/Ethnicity (choose the code each member most closely identifies with): **AI**-American Indian/Alaska Native, **A**-Asian, **B**-Black/African American, **H**-Hispanic/Latino, **N**-Native Hawaiian/Other Pacific Islander, **W**-White/Caucasian

** If you do not have a current primary care provider, or if you're not sure they are on your provider network(s), you can find out at PacificSource.com/find-a-provider, or you may call customer service for assistance at (877) 590-1596.

Section 3: Adding Family Members

Choose the type of coverage each person is enrolling in - **medical coverage, dental coverage** or both **medical and dental.** Nobody to add? Skip to Section 4. If you need to add more family members, please attach additional pages.

Coverage	Name (Last, First, MI)	Relationship to Employee	Gender	Birth Date	SSN	Race/Ethnicity*	Primary Care Provider**
☐ Medical ☐ Dental			☐ M ○ F				
☐ Medical ☐ Dental			☐ M ○ F				
☐ Medical ☐ Dental			☐ M ○ F				
☐ Medical ☐ Dental			☐ M ○ F				
☐ Medical ☐ Dental			○ M ○ F				
☐ Medical ☐ Dental			○ M ○ F				

Child Custody: If you, your spouse, or your domestic partner are a Court Ordered Guardian or are required to provide coverage for a child from a previous relationship, then you must complete this section in addition to the previous section and provide a copy of the legal documentation that shows responsibility for medical expenses. Please use additional paper if needed.

Child's Name _____

Custodial Parent's Name _____

Mailing Address _____

Person Required to Provide Insurance _____

Legal Custody:
☐ Mother
○ Father
○ Joint
○ Other

Section 4: Other Coverage

Health Coverage Information: Do you or any person listed on this application currently have health insurance? ☐ Yes ○ No
If yes, complete the following and attach proof with dates of coverage.

Name	Medical Insurance Carrier	Coverage Dates	Will Coverage Continue?	Coverage Type(s)
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ○ No	☐ Medical ☐ Vision
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ○ No	☐ Medical ☐ Vision

Dental Coverage Information: Do you or any person listed on this application currently have dental insurance? ○ Yes ○ No
If yes, complete the following and attach proof with dates of coverage.

Name	Dental Insurance Carrier	Coverage Dates	Will Coverage Continue?
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ○ No
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ○ No

Medicare: If you or any person listed on this application has Medicare, indicate coverage: ○ Part A ○ Part B ○ Part D

Section 5: Declination of Coverage

Unless declining coverage for someone on the plan, skip to Section 6.

I hereby decline coverage for myself and/or my spouse/domestic partner/eligible dependents in the group plan that was offered by my employer. I understand that by declining coverage, I and/or my spouse/domestic partner/eligible dependents must wait until my employer's next open enrollment period to enroll unless I and/or my spouse/domestic partner/eligible dependents qualify for a special enrollment period.

Check the type of coverage and reason for coverage being waived for the employee and/or spouse/domestic partner/dependent(s):

Coverage waiving	Person(s) waiving coverage (First, MI, Last)	Coverage waiving	Person(s) waiving coverage (First, MI, Last)
○ Medical ○ Dental	Employee	○ Medical ○ Dental	Spouse/Domestic Partner
○ Medical ○ Dental	Dependent Child	○ Medical ○ Dental	Dependent Child
○ Medical ○ Dental	Dependent Child	○ Medical ○ Dental	Dependent Child
○ Medical ○ Dental	Dependent Child	○ Medical ○ Dental	Dependent Child

Medical Waiver – Required if Employee is declining medical coverage.

○ I have qualifying medical coverage through (list carrier name and check coverage type):
Name of Insurance Carrier _____
Through: ○ My other employer ○ My spouse's employer ○ My parent's employer ○ Medicare ○ Medicaid ○ VA/Tricare ○ Indian Health Service

○ I have other medical coverage through an Individual Policy. ○ I do not have other medical coverage.

Dental Waiver – Required if Employee is declining dental coverage.

○ I have qualifying dental coverage through (list carrier name and check coverage type):
Name of Insurance Carrier _____
Through: ○ My other employer ○ My spouse's employer ○ My parent's employer ○ Medicare ○ Medicaid ○ VA/Tricare ○ Indian Health Service

○ I have other dental coverage through an Individual Policy. ○ I do not have other dental coverage.

Notice of enrollment rights: If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends.

In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

Section 6—Electronic Communications Agreement

By checking the "Yes" box below, you affirmatively consent to the following: (1) to submit your application for enrollment on a PacificSource group policy filed electronically over a secured internet connection, (2) your electronic submission has the same force and effect as if you had submitted a paper application to PacificSource with your signature, (3) to receive secured electronic communications from PacificSource regarding your application and/or enrollment status, changes in insurance coverage, and termination of coverage, and (4) to keep PacificSource informed of your current email address so we may continue to correspond with you.

Your consent continues while the plan you enroll in is effective. You may, at any time, opt out of electronic communications. You may request a free paper copy of your application and/or enrollment information by contacting our Commercial Enrollment and Billing Department via email at membership@pacificsource.com, or by phone at (866) 999-5583. Electronic communications are offered as a convenience only. Your decision to not receive electronic communications will not affect your enrollment. There is no charge associated with switching to paper.

PacificSource highly recommends you keep a copy of your application and any associated materials.

In order to complete the application electronically, you must have a personal computer or other device capable of accessing the internet and the ability to view and revise Portable Document Format (PDF) files. PacificSource may also send PDF documents to you as part of the application process. You can obtain a free copy of software to view PDF files at http://get.adobe.com/reader/. PacificSource takes the security of electronic information and communications seriously. If you have any questions about our encryption, technical hardware or software, or our security policies and procedures, please contact us at membership@pacificsource.com.

I agree ☐ Yes ◯ No

Email _____

Section 7: Acknowledgement and Declaration

Subscriber acknowledgement: I acknowledge and understand that PacificSource Health Plans may request or disclose health information about me or my dependents (persons listed for benefit coverage on this enrollment form) for the purpose of facilitating healthcare treatment, payment for healthcare services, or for business operations necessary to administer healthcare benefits; or as required by law. *This acknowledgement does not apply to obtaining information regarding psychotherapy notes*. A separate authorization will be used for this information. For more information about such uses and disclosures please refer to our Privacy Policy that is available at **PacificSource.com**.

Accuracy of enrollment information: I affirm that the answers given in this application are complete, true and correct to the best of my knowledge. I agree to promptly inform PacificSource Health Plans in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Any person who, with an intent to knowingly defraud, files this application with materially false information or conceals material information, may be subject to criminal and civil penalties and PacificSource Health Plans may cancel such person's membership and refuse to pay their claims.

Employee Signature _____ **Date** _____

What Happens After You Submit Your Application

We'll begin processing the applications for your group. In the coming weeks, you'll receive a few things from us. To get information faster, include your email address in your application.

1. Soon, we'll send an email or postcard with information about using your plan and answers to common questions.
2. Later, look for your ID cards in the mail close to the date your plan begins.

IDAHO

Mail: 408 E Parkcenter Blvd, Ste 100, Boise, ID 83706
Fax: (208) 433-4600

Discrimination Is Against the Law

PacificSource Health Plans 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 or, for TTY users, (800) 735-2900, 7:00 a.m. to 5:00 p.m.

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. 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, the PacificSource 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 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, DC 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at HHS.gov/ocr/office/file/index.html.

Amharic	ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (888) 977-9299 (መስማት ለተሳናቸው: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (888) 977-9299 (رقم هاتف الصم والبكم: 711).
Bantu	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (888) 977-9299 (TTY: 711).
Cambodian	បើ ប្រយ័ត្ន៖ សិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (888) 977-9299 (TTY: 711)។

Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (888) 977-9299 (TTY: 711)。
Cushite-Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (888) 977-9299 (TTY: 711).
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez (888) 977-9299 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (888) 977-9299 (TTY: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (888) 977-9299 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(888) 977-9299 (TTY:711）まで、お電話にてご連絡ください。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (888) 977-9299 (TTY: 711)번으로 전화해 주십시오.
Laotian	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (888) 977-9299 (TTY: 711).
Nepali	ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (888) 977-9299 (टटिविाइ: 711) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring (888) 977-9299 (TTY: 711).
Pennsylvania Dutch	Wann du [Deitsch (Pennsylvania German/Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call (888) 977-9299 (TTY: 711).
Persian-Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با (888) 977-9299 (TTY: 711) تماس بگیرید.
Punjabi	ਧਆਿਨ ਦਓਿ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਚਿ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (888) 977-9299 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (888) 977-9299 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (888) 977-9299 (телетайп: 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (888) 977-9299 (TTY–Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 977-9299 (TTY: 711).
Tagalog	UNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (888) 977-9299 (TTY: 711).
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (888) 977-9299 (TTY: 711).
Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (888) 977-9299 (телетайп: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (888) 977-9299 (TTY: 711).

DELTA DENTAL

www.deltadentalid.com

Enrollment/Change Form

DELTA DENTAL OF IDAHO
PO Box 2870; Boise, ID 83701
(208) 489-3582

☐ **Enrollment Form:** *Complete* Sections I-III ☐ **Change Form:** *Complete* Sections I-IV

I. EMPLOYEE INFORMATION *(PLEASE PRINT)*

Name (First) (Middle Initial) (Last) | **Subscriber Number** or **SSN#** | **Date of Birth** (mo/day/year) | ☐ Male ☐ Female

Mailing Address (Street or Route) | **City, State, Zip**

Telephone #: | **Date Employed Full-time:** | **# Hours Worked/Week:** | Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

E-mail Address: | *By providing my email address, I agree to receive communications regarding my Policy electronically. This authorization may be revoked by calling Customer Service at (800) 356-7586.*

Name of Employer: Bar 7, LLC | **For Employer Use** | **Group Number:** 4617 | **Effective Date:**

II. DEPENDENT INFORMATION *(List all family members you wish to enroll)*

	Relationship to Applicant	SSN#	Dependent's Name (First, MI, Last)		Date of Birth (mo/day/year)
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	
☐ Add ☐ Remove	☐ Spouse ☐ Child ☐ Stepchild ☐ Other			☐ Male ☐ Female	

III. OTHER DENTAL COVERAGE *(Medical coverage information is not required)*

Do you or your dependents have **dental coverage** under another benefit plan? ☐ Yes ☐ No *If yes, please complete this section*

Name of Covered Person	Name of Covered Person's Place of Employment	Relationship to You	Date of Birth (mo/day/year)

Name of Dental Carrier	Dental Carrier's Address	Covered Person's Group #

Are you and all dependents listed above on the plan?
☐ Yes ☐ No If No, list covered dependents.

IV. CHANGE REQUESTS

Change current enrollment due to: ☐ Loss of previous coverage ☐ Marriage ☐ Divorce ☐ Birth ☐ Death ☐ Other ______ Date event occurred ______

Change my address to: | Change my email to:

Change my name from: | To:

I hereby apply for the group coverage for which I may be eligible, and I authorize the release of my records to Delta Dental of Idaho.
I understand completion of this form does not guarantee eligibility and coverage will commence when all necessary documentation has been approved.

Employee Signature: ______ Date: ______