MEDICAL AND DENTAL ACCEPTANCE LETTER

[Date] SAMPLE

[Member Name]
[Member Address]
[City, State, Zip]

Reference #: [R #]

Thank you for your application to PacificSource Health Plans. PacificSource offers a variety of insurance options for you and your family. At this time, the following individual(s) have been approved for the plan(s), effective date and premium(s) listed below:

Approved Applicants: [names of members]
Effective Date: [plan effective date]
Requested medical plan: [plan] Monthly medical premium: [$x.xx]
Requested dental plan: [plan] Monthly dental premium: [$x.xx]

Please note: this signed letter, along with your first month's premium, must be received by [date] in order to activate coverage.

If you are interested in another medical plan, you would be eligible for any plan that has a lower premium and may choose it without having to go through the underwriting process. Please see the attached rate sheet.

If you would like to change your requested effective date, you may do so, but it must be a date within 60 days of the date you signed the application for coverage. For a new policy, you may choose an effective date of either the 1st or the 15th of the month. If you are adding a dependent to an existing policy, you must choose a date of the 1st of the month.

To accept our offer of coverage, please check the appropriate box and sign and return this letter along with your first month's premium. If the applicant is under age 18, a parent or guardian signature is required.

☐ I accept the requested plan and effective date that was approved.

☐ I would like to choose a medical plan with a lower premium and/or change my effective date.

Alternative effective date: ________________________________

Alternate plan: ____

PacificSource
HEALTH PLANS

Monthly premium: ___________________________________

If you have any questions, please contact your insurance agent or our Individual Sales Department. You can reach us by phone at (541) 684-5585 or toll-free at (866) 695-8684, or by e-mail at individual@pacificsource.com.

Prior to signing and submitting this acceptance letter, please notify us (in writing) of any changes in your health status since you signed the application, as this may affect your plan selection and premium.

___________________________	__________	___________________________	__________
Applicant signature	Date	Spouse signature (If applying for coverage)	Date
Signature of child age 18 or older (If applying for coverage)	Date	Signature of child age 18 or older (If applying for coverage)	Date

Required if applicant is a minor:

___________________________	__________	___________________________
Signature of (check one): ☐ Parent ☐ Guardian	Date	Printed name of Parent/Guardian

Please return this signed letter, along with your first month's premium payment to:

Attn: Individual Sales
PacificSource Health Plans
PO Box 7068
Eugene, OR 97401

Thank you,

PacificSource Individual Sales

cc: [Agent Name]