



Enrollment Application and Waiver of Coverage—Oregon

Group Policy No. _____

Subgroup No. _____

Class No. or Classification _____

Section 1— Enrollment Information

Employer/Group Name _____ 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 _____ Race/Ethnicity* _____

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

Primary Care Physician/Dentist** _____

Enrollment Due to:

- New Group
- Open Enrollment
- New Hire
- Adding Dependent(s)
- Involuntary Loss of Other Group
- Dental

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)

Date of Qualifying Event:

(Attach proof of event)

Social Security No. _____

Are you enrolling in medical coverage? Yes No Are you enrolling in dental coverage? Yes No **If you are declining coverage then skip to section 5.**

*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 physician/dentist, 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

Coverage	Name (Last, First, MI)	Relationship to Employee	Gender	Birth Date	SSN	Race/Ethnicity*	Primary Care Physician/Dentist**
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 Dental Vision
	Carrier Name: Policy No.: Phone:	Begin: End:	Yes No	Medical Dental Vision

Dental Coverage Information: If you or any person listed on this application have or has had dental insurance at anytime within the last 24 months then 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

Section 5—Declination of Coverage

I hereby decline coverage for myself and/or my eligible dependents in the group plan that was offered by my employer. I understand that by declining coverage, I and/or my eligible dependents must wait until my employer's next open enrollment period to enroll unless I and/or my eligible dependents qualify for a special enrollment period. Check the type of coverage and reason for coverage being waived for the employee and/or dependent(s):

Employee/Dependent Name	Medicare	Medicaid	Tricare	Indian Health Services	Other Qualifying Coverage	Individual	Other Group Coverage	Insurance Carrier
					Individual Group		Spouse Parent Another Employer	
					Individual Group		Spouse Parent Another Employer	

Do not have other health coverage and not enrolling because _____

Do not have other dental coverage and not enrolling because _____

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 _____