

This enrollment application contains two parts: the Disclosures Section and the Enrollment Information Section.

- **Read the Disclosures Section carefully** to help you understand certain requirements of your employer's health plan.
- **Detach the Disclosures page** and save it for future reference.
- **Complete the Enrollment Information Section.** Be sure to answer everything in this application that applies to you.
- **Sign and date the form.**
- **Return the Enrollment Information page to your plan administrator.**

Employee and Family Members You Wish to Enroll – Guidelines for Section 3

Social Security Numbers – A Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers to report information that the Secretary of the Department of Health and Human Services requires for purposes of coordination of benefits. In order for them to coordinate Medicare payments with other insurance benefits properly, they rely on the collection of both the Social Security Number (or Medicare Health Insurance Claim Numbers) and the Employer Identification Number. Therefore, please provide Social Security Numbers for each family member listed.

Dependents – As employer groups renew on or after September 23, 2010, dependents of a covered employee who meet one of the following requirements are also eligible for enrollment. If unsure of dependent eligibility, please confirm with your employer.

- *Spouse.* The employee's lawfully married spouse.
- *Domestic partner.* The employee's domestic partner registered with the State or Oregon. *[Other domestic partners are not eligible unless your policy is otherwise endorsed based on criteria outlined in our affidavit. See your plan administrator with questions.]*
- *Dependent child.* Any natural child, stepchild, or adopted child of employee, spouse, or domestic partner under age 26 regardless of the child's place of residence, marital status, or financial dependence on the employee. *[Some grandfathered large employers exclude coverage to dependents that are eligible to enroll as an employee or spouse in another employer-sponsored health plan.]*
- *Disabled dependent child.* A disabled child of any age who is unmarried; not in a domestic partnership, registered or otherwise; is otherwise eligible; and has been continuously incapable of self-sustaining employment since turning age 26 because of a mental disability or physical handicap. Documentation from the child's attending physician attesting to the incapacity and a review of the child's functional status by PacificSource is required.
- *Dependent family member.* A brother, sister, niece, nephew, or grandchild under 19 years of age who is unmarried; not in a domestic partnership, registered or otherwise; and the employee is designated by a court as legal guardian with the expectation that the dependent family member will live in the employee's household at least one year.

No other family or household members are eligible for coverage unless this contract is amended by endorsement to specify otherwise.

Medical Pre-Existing Condition and Other Exclusion Periods – Guidelines for Section 4

The following rules apply to all size employer groups, unless a large employer of 100 more employees is endorsed otherwise:

What is a pre-existing condition? A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended by or received from a licensed provider during a six-month "look back" period. That look back period is the six-month period ending on your enrollment date or the first day of your employer's probationary waiting period, whichever is earlier. For late enrollees, the look back period ends on the effective date of coverage.

How long is coverage for pre-existing conditions excluded or reduced on standard contracts? Preferred plans exclude pre-existing conditions for six months. The six-month period begins on your enrollment date. However, if your employer's waiting/probationary period is longer than four months and you do not have creditable prior coverage, this period will be reduced so that pre-existing conditions are covered 10 months after your waiting/probationary period began. Pre-existing condition waiting and reduction periods do not apply to members under age 19.

What other medical conditions have exclusion periods and how long are they? Organ transplants and related services are excluded for 24 months, unless otherwise endorsed by large employer. Preferred plans also exclude elective procedures, surgery for ear infections, removal of tonsils or adenoids, and sterilization for six months (exclusion does not apply to Prime or Choice plans).

If I had prior health coverage, will my exclusion or reduction periods be shortened or eliminated? You can receive credit toward the exclusion or reduction periods if you had qualifying health coverage before enrolling in this plan. For credit, there can not be more than a 63-day gap between your last day of coverage under the prior health plan and your first day of coverage (or first day of your employer's eligibility waiting/probationary period) under this plan. Your prior coverage must have been a group health, COBRA, state continuation, individual health insurance, student health, Medicaid, Medicare, TRICARE, State Children's Health Insurance Program, or through risk pools and Peace Corps. If you were covered as a dependent under a plan that meets these qualifications, you qualify for credit. Many people elect the COBRA or state continuation available under a prior plan to prevent more than a 63-day gap in coverage.

It is your responsibility to show in writing that you had creditable coverage. If you qualify for credit, we will count every day of coverage under your prior plan toward the exclusion periods for pre-existing conditions, specified conditions, and transplants.

How can I prove my prior creditable coverage? You can show evidence of creditable coverage by sending us a Certificate of Creditable Coverage from your previous health plan. The certificate shows how long you were covered under your previous plan and when your coverage ended. If you do not have a certificate of prior coverage, contact your previous insurance company or plan sponsor (such as your former employer, if you had a group health plan). All health plans, insurance companies, and HMOs are required by law to provide these certificates on request, and most issue these certificates automatically whenever someone's coverage ends.

Example of how your plan's exclusion period rules work. Mike worked at Oldco, is 32 years old, and was covered under Oldco's group health plan for five months. He did not have any health coverage before his Oldco group plan.

Mike quit his job at Oldco and did not elect the COBRA continuation coverage. Exactly 60 days after quitting his job at Oldco, he was hired for a full time, benefits eligible job at Newco. Newco has a PacificSource group health plan with the same exclusion periods and rules as Oldco. Mike enrolled in Newco's group plan as soon as he satisfied Newco's eligibility probationary period.

- Mike will receive credit because the gap between his last day under Oldco's plan and his hire date at Newco was less than 63 days.
- Mike will receive five months of prior coverage credit for the Oldco plan, so his pre-existing exclusion period is reduced to one month. That one-month period begins on his enrollment date (after he satisfies Newco's eligibility probationary period).
- Mike's pre-existing conditions look back period is the six months ending on his hire date.
- The other specified conditions (elective procedures, surgery for ear infections, removal of tonsils/adenoids, and sterilization) are excluded for one month; transplants are excluded for 19 months (24 months reduced by five months of prior coverage).

Special Enrollment Rights

Special Enrollment Periods – Some employers allow employees with other group health coverage to waive this plan's coverage. In that case, both you and your family members may decline this health coverage during your initial enrollment period. If you are eligible to decline coverage and wish to do so, you must submit a written waiver of coverage to PacificSource through your employer. You and your family members may enroll in this plan later if you qualify under Rule #1, Rule #2, or Rule #3 below.

If the agreement between PacificSource and your employer requires all eligible employees to participate in this plan, you must enroll during your initial enrollment period. However, your family members may decline coverage, and they may enroll in the plan later if they qualify under Rule #1, Rule #2, or Rule #3 below.

To find out if your employer's plan allows employees to decline coverage, ask your health plan administrator.

- *Special Enrollment Rule #1* – If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members may enroll in the plan later if other coverage ends involuntarily. "Involuntarily" means coverage ended because continuation coverage was exhausted, employment terminated, the number of hours of employment were reduced below the employer's minimum requirement, the other insurance plan was discontinued or the maximum lifetime benefit of the other plan was exhausted, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation. You must request enrollment within 31 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.
- *Special Enrollment Rule #2* – If you acquire new dependents because of marriage, domestic partnership, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired dependents at that time. You must request enrollment within 31 days after the marriage, registration of the domestic partnership, birth, or placement for adoption. In the case of marriage and domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.
- *Special Enrollment Rule #3* – If you or your dependents become eligible for a premium assistance subsidy under Medicaid or a State Children's Health Insurance Program, you may be able to enroll yourself and/or your dependents at that time. To do so, you must request enrollment within 60 days of the date you and/or your dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollee – A "late enrollee" is an otherwise eligible employee or dependent who does not qualify for a special enrollment period explained above, and who: did not enroll during the 31-day initial enrollment period; or enrolled during the initial enrollment period but discontinued coverage later.

Medical Large Employer Groups – A late enrollee may enroll by submitting an enrollment application to your employer during an open enrollment period designated by your employer, just prior to the plan's anniversary date. When you or your dependents enroll during the open enrollment period, plan coverage begins on the plan's anniversary date.

Waiving Coverage

If your employer has an agreement with PacificSource allowing employees to waive group coverage, you and your family members may decline coverage when you are first eligible. To decline coverage, complete a **Waiver of Coverage form** instead of this form.

For more information on your plan's special enrollment provisions, please refer to your Member Benefit Handbook or contact the PacificSource Membership Department at (541) 684-5583 or (866) 999-5583.

**Oregon Medical / Dental
ENROLLMENT
APPLICATION**



PO Box 7068 • Eugene, OR 97401
(541) 684-5583 or (866) 999-5583
Membership Fax (541) 225-3642
Marketing Fax (541) 225-3645
PacificSource.com

Please write legibly in black or blue ink. Complete all applicable sections.

Group Policy No. G0020720	Subgroup/Class No, Active <input type="checkbox"/> P002-1002 Retiree <input type="checkbox"/> P002-7002 COBRA <input type="checkbox"/> P002-9002	PPO <input type="checkbox"/> P001-1001 <input type="checkbox"/> P001-7001 <input type="checkbox"/> P001-9001	HIP <input type="checkbox"/> P006-1004 <input type="checkbox"/> P006-7003 <input type="checkbox"/> P006-9003	IAFF <input type="checkbox"/> P006-1005 <input type="checkbox"/> P006-7004 <input type="checkbox"/> P006-9004	NON <input type="checkbox"/> P006-1005 <input type="checkbox"/> P006-7004 <input type="checkbox"/> P006-9004	OPEU-SEIU <input type="checkbox"/> P006-1006 <input type="checkbox"/> P006-7005 <input type="checkbox"/> P006-9005
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Section 1 – Enrollment Information

Employer/Group Name City of Springfield	Effective Date month _____ day _____ year _____
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Date of Full Time Hire (required) month _____ day _____ year _____	Number of Hours Worked Per Week	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Other
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Section 2 – Employee Information

Employee Last Name	First Name	M.I.
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Mailing Address	City	State	Zip code
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Home Phone No.	E-Mail Address	Job Title
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Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner–If domestic partner, are you registered with the State of Oregon? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you an active employee? Yes No If yes, complete Section 2A. If no, complete Section 2B.

Section 2A – Type of New Enrollment I am <input type="checkbox"/> New Employee <input type="checkbox"/> Adding dependent spouse, partner, or child Date of qualifying event: _____ <i>Attach proof of event</i> Event: <input type="checkbox"/> New Hire <input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Registration <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Court Order <input type="checkbox"/> Involuntary loss of other group coverage <input type="checkbox"/> Late Enrollment or Open Enrollment (<i>see disclosure for information</i>)	Section 2B – Continuation of Coverage I am eligible for <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation Date of qualifying event: _____ Event: <input type="checkbox"/> Termination of employment or reduced hours <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Dependent no longer meets eligibility <input type="checkbox"/> Death of a covered employee
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Section 3 – Employee and Family Members You Wish to Enroll

***Race / Ethnicity** (choose the code each family member would most closely identify with): **A**-American Indian/Alaska Native, **B**-Asian, **C**-Black/African American, **D**-Hispanic/Latino, **E**-Native Hawaiian/Other Pacific Islander, **F**-White/Caucasian

Name	Sex	Birth Date	Social Security Number (Required–refer to disclosure)	*Race / Ethnicity
Employee				
Spouse or Domestic Partner				
Dependent Child				

If you or your spouse/domestic partner are a court-ordered guardian of any dependent listed above, identify and provide proof:

Name(s): _____ Type: Grandchild Niece/Nephew Sibling Other _____

Primary language spoken in household: English Español Other:

Para asistirle en español, por favor llame al numero (800) 624-6052, ext. 1009, de Lunes a Viernes, 7:00 a.m. hasta 5:00 p.m

Section 4 – Other Coverage

Current or Prior Coverage Information – Do you or any person listed on this application have or have had health insurance in the last 24 months? No Yes If yes, complete the following **and** attach proof with dates of coverage.

Name(s)	Insurance Carrier	Date of coverage	Will Coverage Continue?	Type of Coverage
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree

Child – Is any child listed on this application eligible to enroll in any other employer-sponsored group health plan as an employee or spouse? No Yes If yes, list name(s):

Married or partner – Is your spouse or domestic partner employed? No Yes If yes, self employed? No Yes

Medicare – If you or any person on this application has Medicare, is coverage? Part A Part B Part D

Name	Original Effective Date	Medicare No. (include alpha prefix)	Reason for Medicare Entitlement
			<input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement
			<input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement

Section 5 – Child Custody Information

If you are enrolling children of a previous relationship, you must complete this section. List court ordered coverage in Section 4 above. Oregon law requires PacificSource to provide plan information to the custodial parent.

Child's Name	Whose Child	Joint Custody	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone No.	If Court Order, Name Responsible for Insurance
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Section 6 – Acknowledgement and Declaration

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating health care treatment, payment, or for business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist, or other physical or behavioral healthcare practitioner;
- A clinic, hospital, long term care, or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- An insurance carrier or group health plan.

Health or dental information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

*This acknowledgement does not apply to obtaining information regarding psychotherapy notes.
A separate authorization will be used for this information.*

I affirm that the answers given in this application are complete and correct.

Employee Signature

Date