



# Enrollment Application and Waiver of Coverage— Oregon

## 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.

***Please keep this page for your records.***



# 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**
<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> M <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
	Carrier Name: Policy No.: Phone:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Carrier Name: Policy No.: Phone:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/>	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Another Employer					
	<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/>	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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](mailto: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](mailto: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** \_\_\_\_\_

## 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) 779-9299, TTY 711, fax (541) 684-5264, or email [crc@pacificsource.com](mailto: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](http://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](http://HHS.gov/ocr/office/file/index.html).

Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ (888) 977-9299 (መስማት ለተሳናቸው፡ 711)።
Arabic	711) (مكبل او مصلا فتاه مقر) (888) 977-9299 مقر ب ل ص ت ا . ن ا ج م ا ب ك ل ر ف ا و ت ت و ي و غ ل ل ا د ع ا س م ل ا ت ا م د خ ن ا ف ، غ ل ل ا ل ك ذ ا ش د ح ت ت ن ك ا ا ذ ا : ع ط و ح ل م
Bantu	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (888) 977-9299 (TTY: 711).
Cambodian	បរើ ប្រយ័ត្ន៖ សិនជាអ្នកនិយាយ ភាសាខ្មែរ, សម្រាប់ជំនួយសេវាកម្មភាសា ដទៃយើងគិតឈ្នួល គឺអាចមានសំរាប់បរើអ្នក។ 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	XIYYEEFFANNA: 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, ໂດຍບໍ່ຄ່າ, ຄຸ້ມຄອງພ້ອມໃຫ້ທ່ານ. ໂທ (888) 977-9299 (TTY: 711).
Nepali	ध्यान दनुहोस्: तपाइँले नेपाली बोल्नुहुन्छ भने तपाइँको नमिति भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (888) 977-9299 (टिडिडिडि: 711) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistanstjenester tilgjengelige for deg. Ring (888) 977-9299 (TTY: 711).
Pennsylvania Dutch	Wann du [Deutsch (Pennsylvania German/Dutch)] schwetzsch, 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	دشاب یم مه‌ارف امش ی‌ارب ناگی‌ار تروصب ین‌ابز تالی‌هست، دینک یم وگتفگ ی‌سراف نابز هب رگا: رجوت دیری‌گب سامت (888) 977-9299 (TTY: 711)
Punjabi	ਯਭਿਅਨ ਦਓ: 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).