Fern Ridge School District #28J

Enrollment and Change Form

Group Name: Fern Ridge School District	Subgroup No:	Requested Effective Date

Enrollment Information

Purpose of Application: Select One

Employee Date of Hire:	Date employee became eligible:	Date of Qualifying Event:	Employee Type: Select One	Earnings: $_____ Select One	Hours per week:
Employer initials:	Date:	If COBRA, indicate number of months eligible for coverage: Select One		COBRA qualifing event:	

Employee Information

Employee name: (Last) (First) (MI)		Home phone:	Email address:	
Married? If yes, list spouse as waiving or enrolling below: Select One		Social Security Number:	Job Title:	
Home address:		City:	State:	Zip:
Mailing address *(if different than home address)* :		City:	State:	Zip:

Employee and Family Members

Medical Plan Choice: Select One

Add	Waive/ Drop	If waiving coverage, select reason:	Gender	Relationship	Name (last) (first) (MI)	Date of birth	Social Security #
☐	☐	○ Other Group Coverage ○ Other:	Gender	Self	Same as above		
☐	☐	○ Other Group Coverage ○ Other:	Gender				
☐	☐	○ Other Group Coverage ○ Other:	Gender				
☐	☐	○ Other Group Coverage ○ Other:	Gender				

Employee and Family Members - Continued							
☐	☐	○ Other Group Coverage ○ Other:	Gender				
☐	☐	○ Other Group Coverage ○ Other:	Gender				
☐	☐	○ Other Group Coverage ○ Other:	Gender				
☐	☐	○ Other Group Coverage ○ Other:	Gender				

Does a Dependent have a different mailing address? Name of Dependent(s): _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Other Coverage

Current or Prior Coverage Information: Does any person listed on this application have or have had insurance in the last 24 months? ☐ No ☐ Yes, see below

Name(s)	Insurance Carrier	Date of Coverage	Will Coverage Continue	Type of Coverage
	Name: _____ Policy No: _____ Phone No: _____	Begin: _____ End: _____		
	Name: _____ Policy No: _____ Phone No: _____	Begin: _____ End: _____		

Child Custody Information

If you are enrolling children of a previous relationship, you must complete this section. Also, list court ordered coverage in Other Coverage section above. Regulation require that plan information be provided to the custodial parent.

Child's Name	Whose Child	Joint Custody	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone No.	Name Responsible for Insurance

Life and Long Term Disability

Class	Basic Life Amount	Mark box if you are eligible for the listed coverage:
		☐ Group Life/AD&D ☐ Spouse Life ☐ Dependent Life ☐ Long Term Disability

Primary Beneficiary:	Relationship to Beneficiary	Social Security Number

Street Address	City	State	Zip

Contingent Beneficiary:	Relationship to Beneficiary	Social Security Number

Street Address	City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attached a separate sheet of paper.

Flexible Spending Account

Beneficiary*:	Relationship to Beneficiary:

* Please designate someone over the age of 18 to be the beneficiary for your account. This person will be responsilbe for submitting claims in the event you are not physically able to do so. The beneficiary does not need to be related to you.

Payroll Deducted Group Insurance Premium ☐ Yes ☐ No ☐ N/A $_____ fee per pay period

Benny Card Enrollment ☐ Yes ☐ No $_____ fee per month

I request the following amounts to be reduced from my paycheck:

	Per Pay Period Amount	Annual Amount
Dependent Care Expenses:	$_____	$_____
Unreimbursed Eligible Health-Related Expenses:	$_____	$_____
Administrative Fee:	$3.60	$43.20
Total Authorized Reductions	**$_____**	**$_____**

In applying for enrollment as indicated on this enrollment form, I declare that, to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions attached. The changes on this form supersede all previous forms submitted. If I decline coverage for myself and/or Dependents, I acknowlege that those decline will have to wait to be enrolled until the next open enrollment period or qualifying event.

I certify that the children for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amount remaining in my account(s) not used for eligible expenses incurred during the Plan Year will be forfeited in accordance with current plan provisions and tax laws. I futher understand that the flexible compensation reductions will be in effect for the Plan Year and cannot be revoked unless I experience a qualified change in status. I also understand that the above reductiolns may correspondingly reduce my future Social Security benefits

Employee Signature: _____ **Date: _____**

HealthNet Acknowledgement and Declaration

If your employer's coverage has not yet renewed in 2014, this plan may impose a pre-existing condition exclusion. This means that if you have a medical condition before coming onto our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy, to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption, nor to enrollees under the age of nineteen (19). The pre-existing condition exclusion does not apply to physical or mental injuries sustained as a result of domestic or sexual violence or treatment received for such injuries. You can reduce the length of this exclusion period by the number of days of your prior "Creditable Coverage."

Definition: "Creditable Coverage" means health care coverage under a group or individual Health Benefit Plan, Medicare, Medicaid, military-sponsored health care, a medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool, a Federal Employees' Health Benefit Plan (FEHBP), a public health plan, or a Health Benefit Plan under the Peace Corps Act, except coverage consisting solely of coverage of benefits for which credit is not required under applicable law. Coverage is creditable only if there had not been a gap in coverage exceeding 63 days under Oregon contract or 90 days under Washington contract.

If you are declining enrollment for yourself or your Dependents (including your spouse or Registered Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you previously declined enrollment in this plan for yourself or your Dependents because of coverage under a Medicaid plan or CHIP plan, you can enroll within 60 days of loss of such coverage. If you become eligible for premium assistance under a Medicaid plan or CHIP plan, you or your Dependents can enroll in this plan within 60 days of becoming eligible for premium assistance.

IMPORTANT: THE FOLLOWING TERMS ARE A PART OF THIS APPLICATION. YOU MUST READ THEM CAREFULLY.
DO NOT SIGN THE APPLICATION ABOVE UNTIL YOU UNDERSTAND THESE TERMS.

I, the applicant (employee) on my behalf and on behalf of every covered Dependent listed on this form or added in the future, hereby:

1. Agree that in the event any health care benefits provided to me or any covered Dependent by Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) and/or its representatives are the primary responsibility of Medicare or of any coverage for work-related injuries, illness or conditions, or of any third party on account of any injury, illness, condition, or damage, I will fully inform Health Net of Oregon and/or its representatives and will execute such assignments, liens or other documents which may be necessary to enable Health Net of Oregon and/or its representatives to recover the value of services provided. I further agree that in the event I, any Dependent or any of my family members collect benefits, damages or reimbursement from Medicare, or any other third party with respect to such injury, illness, condition, or damage, I will immediately reimburse Health Net of Oregon and/or its representatives to the full extent of services provided by Health Net of Oregon and/or its representatives in accordance with the group contract/policy; and
2. Agree to be bound by each and every provision of the group contract/policy (including all schedules and attachments which are a part of the group contract/policy) as now in effect and as may be amended in the future, and agree that all my rights are as specifically set forth in the group contract/policy; and
3. Authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group contract; and
4. Acknowledge that I have selected a Primary Care Physician/Provider from the current Health Net of Oregon participating provider network, (for Exclusive Provider Organization (EPO), Triple Option/POS and CommunityCare plans); that this list identifies participating providers as of the date of publication; that changes in a provider's status, and additions to or deletions from this list may occur; and that Health Net of Oregon and/or its representatives neither warrant nor guarantee the availability of any specific participating provider; and
5. Acknowledge that Health Net of Oregon and/or its representatives' benefits are only available if obtained in compliance with all provisions of the group contract/policy; and
6. Acknowledge that all participating providers are independent contractors and are not agents, servants, officers, employees, partners, or joint venturers of or with, and are not controlled by, Health Net of Oregon and/or its representatives; that the participating providers, including primary care physicians, are responsible for the delivery of, or arrangement for, all medical services to me and my Dependents; and Health Net of Oregon and/or its representatives are not and will not be responsible for the deliberate or negligent acts or omissions of any such participating provider or any nonparticipating provider.

PacificSource 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 healthcare treatment, payment, or for business operations necessary to administer healthcare 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.

If declining coverage, I understand that if my other coverage is lost due to termination of employment, termination of the health plan, death of my spouse, or divorce, I must enroll in my employer's plan within 31 days. An employee or dependent that does not enroll within the 31-day initial enrollment period or within 31 days of a qualifying event may enroll later on the policy's anniversary date. An employee or dependent that enrolled and later discontinued coverage may re-enroll in the plan on an anniversary date of the policy following a 24-month waiting period from the date coverage was discontinued.

I affirm that the answers given in this application are complete and correct. I, the applicant, authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group contract.