PacificSource HEALTH PLANS

Enrollment Application and Waiver of Coverage

Group Policy No. G0020166

☐ Subgroup No. _____

☐ Subgroup No. _____

Class No., Classifications or Plan Designs

☐ SmartChoice 1000+25_20	☐	☐	☐
☐ SmartChoice HSA 1500	☐	☐	☐
☐ SmartChoice 5000+35_20	☐	☐	☐
☐ Out of State - PSN 1000	☐	☐	☐
☐	☐	☐	☐
☐ Preventive Dental 2000	☐	☐	☐

Section 1—Enrollment Information

Employer/Group Name Fern Ridge School District

Effective Date (MM-DD-YY) 10-1-2018

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 _____ Social Security No. _____

Enrollment Due to:

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

Date of Qualifying Event:

_____

(Attach proof of event)

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)

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 (888) 977-9299.

Section 3—Adding Family Members

Coverage *Only check dental box if enrolling in PacificSource dental plan.*	Name (Last, First, MI)	Relationship to Employee	Gender	Birth Date	SSN	Race/Ethnicity*
☐ Medical ☐ Dental	Self		☐ M ☐ F			
☐ Medical ☐ Dental	Spouse/domestic partner/dependent (circle one)		☐ M ☐ F			
☐ Medical ☐ Dental	Dependent		☐ M ☐ F			
☐ Medical ☐ Dental	Dependent		☐ M ☐ F			
☐ Medical ☐ Dental	Dependent		☐ 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 Group Coverage	Insurance Carrier
	☐	☐	☐	☐	☐ Spouse ☐ Parent ☐ Another Employer	
	☐	☐	☐	☐	☐ 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** _____

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. 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, 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.