

**GROUP
HEALTH / DENTAL
ENROLLMENT
APPLICATION**



Detach and
keep for your
records.

Instructions

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

- **Read the Disclosures Section carefully.** This information will 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. It is important that you provide all requested information so your benefits can be administered correctly. **Please be sure to sign and date the form.**
- **Return the Enrollment Information page to your plan administrator.**

Disclosures Section

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

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? The plan excludes 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, your exclusion period will be reduced so that pre-existing conditions are covered 10 months after your waiting/probationary period began.

What other conditions have exclusion periods and how long are they? The plan excludes coverage for organ transplants and any related services for 24 months. If you are enrolling in a Preferred plan, your plan also excludes coverage for elective procedures, surgery for ear infections, removal of tonsils or adenoids, and sterilization for six months. (Prime and Choice plans do not have this exclusion.)

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

It is your responsibility to show us you had creditable coverage in writing. If you qualify for credit, we will count every day of coverage under your prior plan toward this plan's exclusion periods for pre-existing conditions, other 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. 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. 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). You have the right to request a certificate from any prior plan, insurer, HMO, or other entity through which you had creditable coverage. If you are unable to obtain a certificate, please contact the PacificSource Membership Services Department and we will assist you.

Example of how your plan's exclusion period rules work. Mike worked at Oldco, 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, Mike 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 your employer's plan. Mike enrolled in Newco's group plan as soon as he satisfied Newco's eligibility waiting/probationary period.

- Mike will receive credit for the Oldco coverage because the gap between his last day under the Oldco 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 conditions exclusion period is reduced to one month. That one-month period begins on his enrollment date (after he satisfies Newco's eligibility waiting/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 or adenoids, and sterilization) are also excluded for one month, and transplants are excluded for 19 months (24 months reduced by five months of prior coverage credit).

Special Enrollment Rights

The PacificSource group health plan offered by your employer contains provisions that, in certain situations, may allow you or your family members to enroll in the plan later if you decline enrollment when you are first eligible. These special enrollment rights affect both you and your eligible family members.

The agreement between PacificSource and your employer may require all eligible employees to participate in the group health plan. In that case, you must enroll in the plan when you first become eligible. However, your family members may decline coverage, and they may enroll in the plan later if they qualify under Rule #1 or Rule #2 below.

Some employers have agreements with PacificSource allowing employees with other group health coverage to waive the PacificSource group coverage. In that case, both you and your family members may decline coverage when you are eligible. You and your family members may enroll in the plan later if you qualify under Rule #1 or Rule #2 below and a "Waiver of Coverage" form was submitted to PacificSource during your initial enrollment period or at the time you disenrolled in the group plan (see Waiving Health Coverage below).

Special Enrollment Rule #1

If you decline enrollment for yourself or your dependents (including your spouse) because of other group health insurance coverage, you or your family members may enroll in the plan later if the other coverage ends involuntarily. "Involuntarily" means coverage ended because continuation coverage was exhausted, employment terminated, work hours 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. To do so, you must request enrollment within 31 days after your other group health insurance coverage ends.

Special Enrollment Rule #2

If you acquire new dependents because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your new dependents at that time. To do so, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Waiving Health Coverage

If your employer had an agreement with PacificSource allowing employees to waive the PacificSource group coverage, both you and your family members may decline coverage when you are first eligible in accordance with that agreement. If you choose to decline coverage, you must complete a Waiver of Health Insurance Coverage form instead of this application.

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

**GROUP
HEALTH / DENTAL
ENROLLMENT
APPLICATION**



PO Box 7068 • Eugene, OR 97401
(541) 686-1242 • (800) 624-6052
Membership Fax (541) 225-3642
Marketing Fax (541) 485-0915
www.pacificsource.com

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

Section 1 – Employer Information

Employer/Group Name		Group Policy No.
Employee Date of Full Time Hire	Number of Hours Worked Per Week	Enrollment Date

Section 2 – Employee Information

Employee Last Name	First Name	M.I.	Social Security Number <i>Write number in boxes across, then darken circles for each number below.</i>																	
Address						-				-										
City	State	Zip code	0	0	0		0	0		0	0	0	0	0	0	0	0	0	0	0
Home Phone No.	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		1	1	1		1	1		1	1		1	1		1	1	
E-Mail Address	Job Title		2	2	2		2	2		2	2		2	2		2	2		2	2
			3	3	3		3	3		3	3		3	3		3	3		3	3
			4	4	4		4	4		4	4		4	4		4	4		4	4
			5	5	5		5	5		5	5		5	5		5	5		5	5
			6	6	6		6	6		6	6		6	6		6	6		6	6
			7	7	7		7	7		7	7		7	7		7	7		7	7
			8	8	8		8	8		8	8		8	8		8	8		8	8
			9	9	9		9	9		9	9		9	9		9	9		9	9

Enrollment

For myself only For myself & family members Add family members: If due to marriage or birth, date: _____
If applying after initial enrollment, state reason coverage was not originally applied for and why coverage is now being applied for:

Section 3 – Family Information

Complete for yourself and each family member you wish to enroll.					PRIME & CHOICE PLANS ONLY*	
Name	Gender	Birth Date	Coverage	Relationship to Employee	First and Last Name of Primary Care Practitioner (PCP)	Established Patient?
Employee			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of dependents over age 18 who are full time students and the school they attend:					*Enrollment in a Prime or Choice plan cannot be done without listing a PCP for each person enrolling. Refer to a Provider Directory or the PacificSource Web site for a listing of PCPs.	

Para asistirle en español, por favor llame al numero (800) 624-6052, ext. 1009, de Lunes a Viernes, 8:00 a.m. asta 5:00 p.m.

Section 4 – Other Coverage

Prior Coverage – You may provide evidence of prior coverage to reduce your medical pre-existing condition exclusion period. (Refer to Disclosures Section)

Did you or any enrolling family members have any prior medical coverage?

No Yes – If yes, please attach proof of prior coverage (certificate of coverage or other proof with dates of coverage)

Existing Coverage

After enrolling with PacificSource, will you or any of your dependents have any other additional health insurance?

No Yes – If yes, please complete the following:

Names of Everyone with Other Current Coverage	Insurance Carrier Name	Insurance Carrier Phone No	Policy or ID Number	Type of Coverage
				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree

If married: Is your spouse employed? No Yes Self employed

Medicare Information

Name of Insured	Type of Coverage	Original Effective Date
	<input type="checkbox"/> Part A <input type="checkbox"/> Part B	

Section 5 – Child Custody Information

If you are enrolling children of a previous marriage, 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	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone No.	If Court Order, Name of Person Responsible for Insurance
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse				

Section 6 – Health Information 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 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