

**Oregon Dental Only
ENROLLMENT
APPLICATION**



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

Group Policy No.	Subgroup No.	Class No, Classification, or Plan Design
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Section 1 – Enrollment Information

Employer/Group Name		Effective Date month _____ day _____ year _____
Date of Full Time Hire (required) month _____ day _____ year _____	Number of Hours Worked Per Week	Are you an owner of this company? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 2 – Employee Information

Employee Last Name		First Name	M.I.
Mailing Address		City	State Zip code
Home Phone No.	E-Mail Address	Job Title	
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		

Are you an active employee? Yes No If yes, complete Section 2A. If no, complete Section 2B.

<p>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>)</p>	<p>Section 2B – COBRA Continuation I am eligible for <input type="checkbox"/> COBRA 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</p>
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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	Gender	Birth Date	Social Security Number	*Race / Ethnicity
Employee				
Spouse or Domestic Partner				
Dependent Child				
Dependent Child				
Dependent Child				
Dependent Child				
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 dental 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 dental 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

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 understand that dental and medical late enrollment provisions are different. An employee or dependent that did not enroll in the dental plan within the 31-day initial enrollment period and does not qualify for a special enrollment period may enroll later on the policy's anniversary date. An employee or dependent that enrolled on the dental plan and later discontinued coverage may re-enroll in the plan on the anniversary date of the policy following a 24-month waiting period from the date coverage was discontinued.

I acknowledge and understand that my 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 dental or health care treatment, payment, or for business operations necessary to administer dental or 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 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.

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

Employee Signature

Date