

Individual and Family Policy Enrollment Form—Dental Only Montana



Thank you for choosing PacificSource!

You may also enroll online at PacificSource.com.

What you'll need to complete this enrollment form:

- A blue or black pen (if you're not filling it out electronically).
- Information, such as your old ID card, from any insurance company that currently or recently covered you or your family. This information is needed to determine creditable coverage.
- A copy of any documentation you may need to show legal guardianship.
- Your health insurance broker's information, if applicable.
- Your first month's premium payment (required before your policy will take effect).

You are eligible to enroll if:

- You are a resident of the state of Montana.
- Your spouse/domestic partner (if applicable) is your legal spouse/domestic partner.
- Your children (if applicable) are your natural or adopted children, under age 26, or you are their legal guardian.

Need help?

If you have questions about any part of this enrollment form, we'd be happy to help. You can reach a PacificSource Coverage Advisor at **855-330-2792**, TTY: 711. We accept all relay calls.

What happens after you submit your application

We'll begin processing your application, and in the coming weeks, you'll receive a few things from us. To get information faster, include your email address in your application.

1. Look for your ID cards in the mail close to the date your plan begins.
2. We'll also mail your full policy.

Please keep a copy of this application for your records.

If you would like to enroll in a PacificSource Individual or Family medical policy, visit the "Shop Plans" page at Shop.Pacificsource.com/individual. Need help? Contact a PacificSource Coverage Advisor at **855-330-2792**.

1 What type of coverage would you like?

New Coverage

For myself only
For myself + my spouse/domestic partner
For myself + my family
For my child(ren) or legal dependent(s) only

Or Change to My Current Coverage

Current PacificSource ID No. _____
(This can be found on your ID card.)
Add family member(s)
Change my plan as shown below

2 Choose a plan

Dental Choice 0-20-50 1000
Dental Choice 0-20-50 1500

Kids Dental Choice 0-20-50
(coverage for members 18 and younger)

These policies include pediatric dental coverage that meets the requirements of the Affordable Care Act.

3 Select a coverage date

What date would you like the coverage to begin? 1st or 15th of ____/____ Mo/Yr.

Enrolling myself and my family

List all family members you would like insured. Only your legal spouse, domestic partner, and dependent children are eligible.

***Gender identity** (optional): **NB**-Non-binary, **TM**-Trans man, **TW**-Trans woman

****Race/ethnicity** (choose the code that each family member would most closely identify with): **AI**-American Indian/Alaska Native, **A**-Asian, **B**-Black/African American, **H**-Hispanic/Latino, **N**-Native Hawaiian/Other Pacific Islander, **W**-White/Caucasian

ICHRA Eligible

Are you enrolling under an ICHRA sponsored plan? Yes No

If applicable, please provide the name of your ICHRA Administrator _____

4 Applicant or parent/guardian (required)

If this is a child/dependent-only policy, PacificSource requires the responsible parent or guardian to include their information.

Name (First, MI, Last) _____

Sex assigned at birth (M/F) ____ Gender identity* ____ Social Security No. _____

Race/ethnicity** ____ Date of birth (MM-DD-YY) _____

Marital Status Single Married Domestic Partnership

Physical address _____

City _____ State _____ ZIP _____ County _____

Phone _____ Email _____

Mailing address (if different) _____

City _____ State _____ Zip _____

5 | Spouse or domestic partner (Skip to section 6 if not enrolling a spouse or domestic partner.)

Name (First, MI, Last) _____

Sex assigned at birth (M/F) ____ Gender identity* ____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

6 | Dependent child (Skip to section 7 if not enrolling dependents.)

Name (First, MI, Last) _____

Sex assigned at birth (M/F) ____ Gender identity* ____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

Dependent child

Name (First, MI, Last) _____

Sex assigned at birth (M/F) ____ Gender identity* ____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

Dependent child

Name (First, MI, Last) _____

Sex assigned at birth (M/F) ____ Gender identity* ____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

Dependent child

Name (First, MI, Last) _____

Sex assigned at birth (M/F) ____ Gender identity* ____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

Dependent child

Name (First, MI, Last) _____

Sex assigned at birth (M/F) ____ Gender identity* ____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

Attach additional pages if needed I have attached ____ pages

7 | **My other insurance information**

Do you, or any people listed on this enrollment form, have other dental insurance coverage, including commercial (employer group or individual dental insurance), or Medicare Advantage coverage? Yes No (If no other coverage, skip to section 8.)

Name of other insurance company(ies) (Include address and phone if available.)

Name(s) of individual(s) covered

Date coverage began ____/____/____ Date coverage ended ____/____/____

Is coverage active? Yes No Policy No. _____

If group insurance, name of group _____

8 | **Certify, authorize, and sign**

Be sure to sign and date the enrollment form on this and the following page. Your spouse or domestic partner's signature is also required (if applicable), as is the signature of any child over the age of 18.

Certification of Completeness and Correctness

It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

I affirm that the answers given in this enrollment form are complete and correct and, if this form includes any intentional misrepresentation of material fact or fraud, PacificSource may modify or cancel the contract, and/or take any other legal action available by law. If accepted, coverage will be in force as of the effective date determined by PacificSource. A representative of PacificSource may contact me to clarify answers on this enrollment form.

Representations made by the applicant are deemed to be representations made on behalf of each person covered under this policy. However, changes to the enrollment form will not be effective until approved in writing by the applicant. An enrollment form received by PacificSource requiring alterations will be modified by amendment and sent to the applicant for a signature. As the applicant, I understand I have the right to inspect the information in my file.

Electronic Communications Consent

By checking the "Yes" box on the next page, you are affirming consent to receive secured electronic communications from PacificSource regarding your application and/or enrollment status, changes in insurance coverage, termination of coverage, and plan and benefit information.

Your consent continues while the plan you enroll in is effective. You may, at any time, opt out of electronic communications by contacting the Customer Service Department at **888-977-9299**. You may request a free paper copy of your application and/or enrollment information by contacting us via email at Individual@PacificSource.com, or by phone at **800-591-6579**. 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.

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 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 Individual@PacificSource.com.

I agree to receive emails: Yes No Email address _____

I agree to receive texts: Yes No Mobile phone number _____

I (We) have reviewed and understand the authorization above.

Applicant or Parent/Guardian:

Printed name of Parent Guardian Applicant _____

Signature _____ Date _____

If enrolling in coverage:

Spouse/domestic partner Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

This enrollment form must be signed and dated. All fields must be completed for this authorization to be valid. Once accepted, PacificSource will provide the policyholder with a copy of this completed form upon request. The policy provides dental benefits only.

9 Producer authorization (Skip to section 10 if you are not working with a producer.)

I, the insurance producer, have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the policy except through written material furnished by PacificSource. The applicant has been informed that the effective date of coverage is assigned only by PacificSource. I hereby certify that information supplied to me by the applicant has been truly and accurately recorded hereon.

Applicant's name (printed) _____

Producer's name (printed) _____

PacificSource producer no. _____

Producer's signature _____ Date _____

10 How do you prefer to pay for future premiums?

Your first month's premium must be received by paying online at InTouch.PacificSource.com/OneTimePayment or by mailing us a check. This policy will not be in effect until the initial payment is received. *We will not accept third-party payments except as required by federal law.*

Please select your method of payment for future premium payments.

Send me a paper bill by mail each month
(Skip to section 11)

Automatic withdrawal from my bank account
(EFT). *The first month's payment cannot be
made by EFT.*

I/We authorize and direct PacificSource Health Plans to withdraw funds as follows:

Amount of monthly withdrawal \$_____ Withdrawals will occur on the 5th of each month.

Select one: Begin transfers on next available date Delay transfers until _____(Mo.)

Bank information

Bank name _____

Account no. _____ Routing no. _____

Account Type

Checking—attach a voided check Savings—attach a voided savings withdrawal slip

This authorization will remain in effect until termination by either party. If the individual policy premium changes, this authorization will automatically be adjusted to authorize withdrawal of an amount equal to the new premium.

Applicant or parent/guardian's name _____ Date _____

Signature of bank account holder _____ Date _____

Important details about the automatic withdrawal of your monthly premiums:

- Initial setup takes up to 30 days. If your policy is accepted and coverage starts sooner than your automatic withdrawal is set up, you may need to pay online or by check until the funds transfer is in place.
- Transfers occur on the 5th of each month. If the 5th falls on a weekend or a holiday, the transfer will occur on the next business day.
- Transfers will be made for the premium balance due.
- If EFT is not set up prior to the bill date of the second month, you may receive a paper bill for the second month.

11 | Are you ready to submit?

Are all sections filled in completely?

Have you attached requested paperwork (e.g., guardianship documentation, etc.)?

Did you select a policy coverage date on page 2?

Have you included your first month's premium payment (required before your policy will take effect)?

Have you selected an ongoing payment option and attached a voided check if needed?

(See section 10.)

Send your signed, completed enrollment form and attachments to us by:

Email: Individual@PacificSource.com

Fax: 541-225-3646

Mail: PacificSource Health Plans, PO Box 7068, Springfield, OR 97475-0068

Thank you for enrolling!

Discrimination is against the law



PacificSource Health Plans and PacificSource Community Health Plans (“PacificSource”) complies with applicable Federal civil rights laws, including Section 1557 of the Affordable Care Act. PacificSource does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)), age or disability. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:

Language assistance services

PacificSource will provide language assistance services for individuals with limited English proficiency (including individuals’ companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:

- Electronic and written translated documents
- Qualified interpreters
- Appropriate auxiliary aids and services for individuals with disabilities (including individuals’ companions with disabilities) to ensure effective communication

Appropriate auxiliary aids and services may include:

- Qualified interpreters, including American Sign Language interpreters
- Video remote interpreting
- Information in alternate formats (including but not limited to large print, recorded audio, and accessible electronic formats)

Reasonable modifications

PacificSource will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

To access our language assistance services, auxiliary aids and services, and for assistance in getting a reasonable modification, please contact Customer Service at **888-977-9299**, TTY: 711. We accept all relay calls.

Continued >

Contact our commercial Customer Service team:

Phone

Toll-free: 888-977-9299

TTY: 711

We accept all relay calls.

Email

CS@PacificSource.com

[PacificSource.com](https://www.pacificsource.com)

Contact our Medicare Customer Service team:

Oct. 1 – Mar. 31:

8:00 a.m. – 8:00 p.m.,
seven days a week

Apr. 1 – Sept. 30:

8:00 a.m. – 5:00 p.m.,
Monday – Friday

Phone

Toll-free: 888-863-3637

TTY: 711

We accept all relay calls.

En Español: 866-281-1464

Email

MedicareCS@PacificSource.com

[Medicare.PacificSource.com](https://www.Medicare.PacificSource.com)



PacificSource

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 PacificSource's Section 1557 Coordinator.

Phone: **888-977-9299**, TTY: 711. We accept all relay calls.

Email: 1557Coordinator@PacificSource.com

Mail: PacificSource
PO Box 7068
Springfield, OR 97475

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

Electronically: OCRPortal.hhs.gov

Mail: U.S. Department of Health & Human Services
200 Independence Avenue, S.W., Room 509F
Washington, D.C. 20201

Notice of availability of language assistance services and auxiliary aids and services

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-431-4135 (TTY: 800-735-2900) or speak to your provider.
አማርኛ Amharic	ማሳሰቢያ:- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጽ ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 800-431-4135 (TTY: 800-735-2900) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 800-431-4135 (800-735-2900) أو تحدث إلى مقدم الخدمة
Bantu-Kirundi	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 800-431-4135 (TTY: 800-735-2900).
ភាសាខ្មែរ Cambodian Non-Khmer	សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដល់សមាជិកក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 800-431-4135 (TTY: 800-735-2900) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។
中文 Simplified Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服 务，以无障碍格式提供信息。致电 800-431-4135 (文本电话：800-735-2900) 或咨询您的服务 提供商。
中文 Traditional Chinese	注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與 服務，以無障礙格式提供資訊。請致電 800-431-4135 (TTY：800-735-2900) 或與您的提供者 討論。

Cushite-Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-431-4135 (TTY: 800-735-2900).
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-431-4135 (TTY: 800-735-2900) an oder sprechen Sie mit Ihrem Provider.
فارسی Farsi	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان تماس بگیرید یا با ارائه‌دهنده (موجود می‌باشند. با شماره 800-431-4135 (تله‌تایپ: 800-735-2900 خود صحبت کنید.
Français French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-431-4135 (ATS : 800-735-2900).
Italiano Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-431-4135 (TTY: 800-735-2900).
日本語 Japanese	注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。800-431-4135 (TTY: 800-735-2900) までお電話ください。または、ご利用の事業者にご相談ください。
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800-431-4135 (TTY: 800-735-2900) 번으로 전화하거나 서비스 제공업체에 문의하십시오.
ລາວ Laotian	ເລື່ອງລາວ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-431-4135 (TTY: 800-735-2900) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
Nepali	ध्यान दनुहोस्: तपाइंले नेपाली बोलुनुहुन्छ भने तपाइंको नम्र्ति भाषा सहायता सेवाहरू नशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 800-431-4135 (टिक्विङ: 800-735-2900) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistentsetjenester tilgjengelige for deg. Ring 800-431-4135 (TTY: 800-735-2900).
Pennsylvania Dutch	Wann du Deitsch (Pennsylvania German/Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800-431-4135 (TTY: 800-735-2900).
ਪੰਜਾਬੀ Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 800-431-4135 (TTY: 800-735-2900) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।
Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 800-431-4135 (TTY: 800-735-2900).

РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-431-4135 (TTY: 800-735-2900) или обратитесь к своему поставщику услуг.
Srpsko-hrvatski Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-431-4135 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 800-735-2900).
Soomaali Somali	FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 800-431-4135 (TTY: 800-735-2900) ama la hadal bixiyahaaga.
Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-431-4135 (TTY: 800-735-2900) o hable con su proveedor.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-431-4135 (TTY: 800-735-2900) o makipag-usap sa iyong provider.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-431-4135 (TTY: 800-735-2900).
українська мова Ukrainian	УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 800-431-4135 (TTY: 800-735-2900) або зверніться до свого постачальника.
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800-431-4135 (Người khuyết tật: 800-735-2900) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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