NWPT Employee Enrollment and Waiver Form

PacificSource HEALTH PLANS

Group Policy No. ______________
Subgroup No. ______________
Class No. or Plan ______________
Are you an owner of this company? ☐ Yes ☐ No

Employer/Group Name ______________ Effective Date ____/____/____ Date of Full-time Hire ____/____/____

Last Name ______________ First Name ______________ MI ______ Hours Worked per Week ______________

Mailing Address ______________ City ______ State ______ ZIP ______

Phone ______________ Email ______________

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership

By providing your email address, you are agreeing to receive email communications from PacificSource.

Enrollment due to:

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

Effective Date:^ ______________

Eligible for COBRA due to:

- ☐ Employment Termination or Reduced Hours
- ☐ Divorce or Legal Separation
- ☐ Death of Employee
- ☐ Dependent No Longer Meets Eligibility

Effective Date:^ ______________

^Attach proof of event

Choose the type of coverage each person is enrolling in (including those waiving coverage). To add more family members, please attach additional pages.

Coverage		Name (Last, First, MI)	Gender	Birth Date	SSN	Race/ Ethnicity*	Primary Care Provider
☐ Medical	☐ Add ☐ Waive	Name: Employee	☐ M ☐ F ☐ X				
☐ Dental (not available in WA)	☐ Add ☐ Waive						
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive	Name: Spouse/Domestic Partner	☐ M ☐ F ☐ X				
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive	Name: Relationship to Employee:	☐ M ☐ F ☐ X				
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive	Name: Relationship to Employee:	☐ M ☐ F ☐ X				
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive	Name: Relationship to Employee:	☐ M ☐ F ☐ X				
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive	Name: Relationship to Employee:	☐ M ☐ F ☐ X				

*Race/Ethnicity (Optional) 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

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

Health and Dental Coverage Information: Have you or any person listed on this application had health or dental insurance in the last 60 days? ☐ Yes ☐ No
If yes, complete the following and attach proof with dates of coverage.

Name	Insurance Carrier	Coverage Dates	Will Coverage Continue?	Coverage Type(s)
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental

Medical Waiver – If Employee is declining medical coverage.

☐ I have qualifying medical coverage through (list carrier name and check coverage type):

Name of Insurance Carrier ____________________

Through: ☐ My other employer ☐ My spouse's employer ☐ My parent's employer ☐ Medicare ☐ Medicaid ☐ VA/Tricare ☐ Indian Health Service

☐ I have other medical coverage through an Individual Policy. ☐ I do not have other medical coverage.

Dental Waiver – If Employee is declining dental coverage. Applies to Idaho, Oregon and Montana only.

☐ I have qualifying dental coverage through (list carrier name and check coverage type):

Name of Insurance Carrier ____________________

Through: ☐ My other employer ☐ My spouse's employer ☐ My parent's employer ☐ Medicare ☐ Medicaid ☐ VA/Tricare ☐ Indian Health Service

☐ I have other dental coverage through an Individual Policy. ☐ I do not have other dental coverage.

Notice of enrollment rights: If you are declining enrollment for you or your dependents (including your spouse/domestic partner) 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 involuntarily or upon your plan's next open enrollment period unless otherwise specified in your member handbook.

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.

Subscriber acknowledgment: 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. 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**.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Employee Signature _____ **Date** _____

You may request a free paper copy of your application and/or enrollment information by contacting us at **(866) 999-5583** or via email at **membership@pacificsource.com**.

Mail: PO Box 7068, Springfield, OR 97475 **Fax:** (541) 225-3642