## **Employee Enrollment** and Waiver Form

Single



	Group Policy No Subgroup No Class No. or Plan
	Are you an owner of this company? Yes No
/	Date of Full-time Hire///////

Employer/Group Name		Effective Date/	/	Date of Full-time Hire	e/	//_	
Last Name	First Name		MI	Hours Worked per W	eek		
Mailing Address				City	State	ZIP _	
Phone	Email						

Marital Status:

Married Domestic Partnership

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

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

Enrollment due to:				5	0		,		1 0
New Group	Coverage		Name (Last, First, MI)	Gende	r Birth Date	SSN	Race/ Ethnicity*	Primary Care	Provide
Open Enrollment New Hire	Medical	Add Waive	Name:	M					
Adding Dependent(s)	Dental (not available in WA)	Add Waive	Employee	X					
Involuntary Loss of Other Coverage	Medical Dental (not available in WA)	Add Waive	Name: Spouse/Domestic Partner	M F X					
ffective Date:^	Medical Dental (not available in WA)	Add Waive	Name: Relationship to Employee:	M F X					
ligible for COBRA	Medical Dental (not available in WA)	Add Waive	Name: Relationship to Employee:	M F X					
Employment Termination or Reduced Hours	Medical Dental (not available in WA)	Add Waive	Name: Relationship to Employee:	M F X					
Divorce or Legal Separation Death of	Medical Dental (not available in WA)	Add Waive	Name: Relationship to Employee:	M F X					
Employee Dependent No Longer Meets Eligibility Effective Date:^	American, <b>H-</b> His <b>Child Custody:</b> child from a pre-	panic/Latir If you, yc vious rela	Choose the code each member no, <b>N-</b> Native Hawaiian/Other Pac pur spouse, or your domestic p tionship, then you must comp	cific Islander, <b>W-</b> White/C partner are a Court Orde lete this section in addi	aucasian ered Gua tion to t	irdian or are req he previous sec	uired to provide tion and provide	coverage for	а
			vs responsibility for medical ex	xpenses. Please use ad Custodial Parent's Name				Legal Custo	dv:
					·			Mother	Fathe
Attach proof of event	Mailing Address								

Person Required to Provide Insurance \_

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 Waive	er – If Employee is declin	ing medical coverage.					
	ying medical coverage th surance Carrier	nrough (list carrier name and	check coverage type):				
Through:	My other employer	My spouse's employer	My parent's employer	Medicare	Medicaid	VA/Tricare	Indian Health Service
I have other	medical coverage throug	gh an Individual Policy.	l do not have other medica	l coverage.			
Dental Waiver	– If Employee is declinir	ng dental coverage. Applies	to Idaho, Oregon and Monta	na only.			
	ying dental coverage throsson the surance Carrier	ough (list carrier name and c	heck coverage type):				
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	n an Individual Policy.	I do not have other dental co	overage.			

**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.

## **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:
  - o Qualified sign language interpreters
  - o 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:
  - o Qualified interpreters
  - o 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) 977-9299, 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.

Bantu Cambodian	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (888) 977-9299 (TTY: 711). បើ ឬរយ័ត្នន៖ សិនជាអ្ននកនិយាយ ភាសាខ្មមផ័, សជាជំនួយផ្នេកែភាសា ដហេយមិនគិតឈ្មនួល គឺអាចមានសំរាប់បំរើអ្ននក។ ចូរ ទូរស័ព្ទ (888) 977-9299 (TTY: 711)។
Arabic	.(711 : مكبلاو مصلا فتاه مقر) 9299-977 (888) مقرب لصتا. ناجملاب كل رفاوتت ةي غللاا قدعاسما تامدخ ناف ،ة غللا ركذا شدحتت تنك اذا : تظوحلما
Amharic	ማስታወሻ: የሚናንሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (888) 977-9299 (መስማት ለተሳናቸው: 711).

Chinese	注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 (888) 977-9299 (TTY: 711)。
Cushite-Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (888) 977-9299 (TTY: 711).
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez (888) 977-9299 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (888) 977-9299 (TTY: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (888) 977-9299 (TTY: 711).
Japanese	注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。(888) 977-9299 (TTY:711) まで、お電話にてご連絡ください。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (888) 977-9299 (TTY: 711)번으로 전화해 주십시오.
Laotian	ໂປດຊາບ: ຖາ້ວາ່ ທາ່ນເວາົພາສາ ລາວ, ການບລໍກິານຊວ່ຍເຫຼືອດາ້ນພາສາ, ໂດຍບ <b>ເ</b> ສງັຄາ່, ແມນ່ມພີອ້ມໃຫທ້າ່ນ. ໂທຣ (888) 977-9299 (TTY: 711).
Nepali	ध्यान दनिुहोस्: तपार्इले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्त भाषा सहायता सेवाहरू नन्शिुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (888) 977-9299 (टटिविाइ: 711) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring (888) 977-9299 (TTY: 711).
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 (888) 977-9299 (TTY: 711).
Persian-Farsi	:TTY) 9299-977 (888) اب .دشاب یم مهارف امش یارب ناگیار تروصب ینابز تالیهست ،دینک یم وگتفگ یسراف نابز هب رگا :مجوت .دیریگب سامت (711
Punjabi	ਧਆਿਨ ਦਓਿ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਚਿ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (888) 977-9299 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (888) 977-9299 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (888) 977-9299 (телетайп: 711).
Serbo- Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezi <b>č</b> ke pomo <b>ć</b> i dostupne su vam besplatno. Nazovite (888) 977-9299 (TTY– Telefon za osobe sa o <b>š</b> te <b>ć</b> enim govorom ili sluhom: 711).
Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 977-9299 (TTY: 711).
Tagalog	UNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (888) 977-9299 (TTY: 711).
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (888) 977-9299 (TTY: 711).
Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (888) 977-9299 (телетайп: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (888) 977-9299 (TTY: 711).