Employee Enrollment and Waiver Form

PacificSource HEALTH PLANS

FOR EMPLOYER TO COMPLETE

Group no. _____ Group name _____

Subgroup no. _____ Class no. or plan name: _____

Date of full-time hire: ____/____/____ Coverage effective date: ____/____/_____

Hours worked per week: _____ Is applicant an owner? ☐ Yes ☐ No

Last name _____ First name _____ MI _____

Mailing address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Marital status: ☐ Single ☐ Married ☐ Domestic partnership

By providing your email address, you agree to receive emails 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:^_____

^Documentation may be required.

Choose the type of coverage each person is enrolling in (including those waiving coverage). To add more family members, please see page 2.

Coverage	**Select one**	**Name** (Last, First, MI)	**Sex assigned at birth**	**Gender identity***	**Social Security number**	**Birth date**	**Race/ Ethnicity****
☐ Medical	☐ Add ☐ Waive	Employee	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Primary care physician (required in OR):					
☐ Medical	☐ Add ☐ Waive	Spouse/domestic partner	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Primary care physician (required in OR):					

***Gender identity** (optional): **A**-Agender, **GF**-Gender fluid, **GN-**Gender nonconforming, **GQ**-Genderqueer, **M**-Man, **NB**-Non-binary, **NL**-Not listed, **P**-Prefer not to answer, **Q**-Questioning or unsure, **TG**-Third gender, **TM**-Trans man, **TW**-Trans woman, **T**-Transgender, **TS**-Two-spirit, **W**-Woman

****Race/ethnicity** (optional): 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, **O**-Other, **W**-White/Caucasian.

Coverage	Select one	Name (Last, First, MI)	Sex assigned at birth	Gender identity*	Social Security number	Birth date	Race/ Ethnicity**
☐ Medical	☐ Add ☐ Waive	Name: Relationship to employee: Primary care physician (required in OR):	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive						
☐ Medical	☐ Add ☐ Waive	Name: Relationship to employee: Primary care physician (required in OR):	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive						

To add more dependents, please attach additional copies of this page.

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 of covered member(s)	Insurance company	Coverage dates	Will coverage continue?	Coverage type(s)
	Company name: Policy no.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Company name: Policy no.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Company name: Policy no.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Company 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 company name and check coverage type):

Name of insurance company _____

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

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

Name of insurance company _____

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, 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** _____

By checking "Yes" 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.

I agree to receive emails: ☐ Yes ☐ No Email address _____

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

You may request a free paper copy of your application and/or enrollment information by emailing us at Membership@PacificSource.com or by calling **866-999-5583,** TTY: 711. We accept all relay calls.

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