Willamette University Student Plan
Domestic Dependent Enrollment Form

PacificSource HEALTH PLANS

1. Enrolling student and family

Student

Name (first, MI, last) _____ Effective date (MM/DD/YY) _____

Student ID number _____ Social Security number _____

Date of birth (MM/DD/YY) _____ Sex assigned at birth ☐ M ☐ F Gender identity* _____ Race/ethnicity** _____

Physical address _____ City _____ State _____ Zip _____

Mailing address (if different) _____

Phone _____ Email _____

***Gender identity** (optional): **A**-Agender, **B**-Boy, **GF**-Gender fluid, **GN**-Gender nonconforming, **GQ**-Genderqueer, **G**-Girl, **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** (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

LIST DEPENDENTS TO BE INSURED BELOW. Dependent enrollment must take place at the time of student enrollment, with the exception of newborn, placement of foster child, adopted children or a qualifying event. Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the student. Dependent coverage will end prior to that time if the dependent is no longer eligible under the plan.

Spouse or domestic partner

Name (first, MI, last) _____ Social Security number _____

Date of birth (MM/DD/YY) _____ Sex assigned at birth ☐ M ☐ F Gender identity* _____ Race/ethnicity** _____

Dependent child

Name (first, MI, last) _____ Social Security number _____

Date of birth (MM/DD/YY) _____ Sex assigned at birth ☐ M ☐ F Gender identity* _____ Race/ethnicity** _____

Dependent child

Name (first, MI, last) _____ Social Security number _____

Date of birth (MM/DD/YY) _____ Sex assigned at birth ☐ M ☐ F Gender identity* _____ Race/ethnicity** _____

Dependent child

Name (first, MI, last) _____ Social Security number _____

Date of birth (MM/DD/YY) _____ Sex assigned at birth ☐ M ☐ F Gender identity* _____ Race/ethnicity** _____

Attach additional pages if needed. ☐ I have attached _____ page(s).

Child custody

If you or your spouse are a court-ordered guardian or are required to provide coverage for a child from a previous relationship, you must complete this section in addition to the above and provide a copy of the legal documentation that shows responsibility for medical expenses. Please use additional paper if needed.

Name of Child	Legal Custody	Custodial Parent Name	Mailing Address	Who is required to provide insurance?
	☐ Mother ☐ Father ☐ Joint ☐ Other			

2. Your other insurance information

Do you, or any people listed on this enrollment form, have other active health or dental insurance coverage, including Medicare, Medicare Advantage, Medicare supplemental, or Pediatric Dental coverage? ☐ Yes ☐ No

Name of other insurance company (include address and phone) _____

_____

Type of coverage: ☐ Medical ☐ Vision ☐ Pediatric Dental ☐ Adult or Family Dental

Name(s) of individual(s) covered under the policy _____

Date coverage began _____ Date coverage ended _____ ☐ Coverage is still in effect

Policy number _____ If group insurance, name of group _____

3. Payment information

The billed amount includes administrative fees, non-insured services, and certain federal, health care fees/assessments. Please use the tables below to calculate total amount due. **Semester premium must be paid in full for coverage to be active. If Fall Semester coverage is elected by the student and dependent(s) and the student retains coverage into the Spring Semester, the dependent(s) will need to have a new application and payment sent to PacificSource (if not elected and paid for upon initial application for Fall Semester).**

- Step 1 – Choose semester student is enrolled in
- Step 2 – Write the number of dependents that are being enrolled
- Step 3 – Calculate and submit the total due

Period rates and coverage dates

Mark which semester the student is in	Coverage Dates	Additional Cost per Dependent	Enter the Number of Dependents Enrolling
☐ Fall Semester	8/01/2024 – 1/05/2025	$1,779.00	
☐ Spring Semester	1/06/2025 – 7/31/2025	$2,329.00	
Calculate Total Premium Due			
$ _____ X _____ = **$** _____ Rate # of Dependents **Total**		*Example: $1,779.00 X 2 = $3,558.00*	

PAYMENT INFORMATION: You can pay via check, money order, or cashier's check (details are provided below). Your cancelled check is your only receipt and notification of coverage. **If payment is not received with this application, you will have 14 days to make your payment in full to PacificSource. Without payment within 14 days, PacificSource will not start coverage for dependents. It is the student's responsibility for timely renewal payment whether or not a renewal notice is received.** Coverage for the dependent will begin only after the school has enrolled the student for PacificSource coverage, and the student has made a timely payment to PacificSource for their dependent(s). If you have questions, please call PacificSource Health Plans at **541-284-7961,** TTY: 711 (we accept all relay calls). Or email MembershipStudentReps@PacificSource.com.

Payment

Make check, money order, or cashier's check in U.S. dollars payable to **PacificSource Health Plans**

Check Amount $ _____ Check Number _____

Mail check and this enrollment form to: **PacificSource Health Plans**
Attn: Membership Student Rep Team
PO Box 7068
Springfield, OR 97475

4. Certify, authorize, and sign

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

NOTICE TO STUDENT. Coverage will start on the effective date of the coverage period unless otherwise stated in the Student Guide. By signing below, the student acknowledges the following: 1) rates are not pro-rated other than as listed on this enrollment form; 2) student meets the eligibility requirements for this coverage as described in the Student Guide; 3) if it is later determined that the student is not eligible, coverage will be deemed to have not been in force and the premium will be returned; and 4) other than eligibility or entry into the Armed Forces, the premium is not refundable. It is the student's responsibility to make a timely renewal payment. This plan is underwritten by PacificSource Health Plans.

Certification of Completeness and Correctness

I affirm that the answers given in this enrollment form are complete and correct. I am providing these answers as part of the enrollment form procedure required by PacificSource to enroll in their insurance coverage. I understand that if this enrollment form contains 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. I will promptly inform PacificSource in writing if anything happens before my coverage takes effect that makes the information I have provided on this enrollment form incomplete or incorrect. I understand and agree that no coverage will be in force until accepted by PacificSource. 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 enrollee 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 enrollee. An enrollment form received by PacificSource requiring alterations will be modified by amendment and sent to the enrollee for signature. As the enrollee, I understand I have the right to inspect the information in my file.

I may, at any time, request a free paper copy of my application and/or enrollment information by contacting the Commercial Enrollment and Billing Department via email at MembershipStudentReps@PacificSource.com or by phone at **541-284-7961**. Electronic communications are offered as a convenience only.

_____ Date _____
Student Signature (Or parent signature if student is under age 18)

_____ Date _____
Spouse/Domestic Partner Signature

_____ Date _____
Dependent Signature (If 18 years or older and enrolling in coverage)