Oregon State University Student Plan

Enrollment Form for Postdoctoral Fellows, Vet Residents, Visiting Scholars

PacificSource HEALTH PLANS

Save time by emailing this completed form to **MembershipStudentReps@PacificSource.com**. Allow 3–5 business days for processing, then call **541-284-7961,** TTY: 711 (we accept all relay calls) to make your payment over the phone. Or you can wait until you receive your first bill, which will include information on how to pay.

Section 1: Student information

Last name _____ First name _____ MI _____

Student ID number _____ Effective date (MM/DD/YY) _____ Date of birth _____

Physical address _____ City _____ State _____ Zip _____

Mailing address (if different) _____ City _____ State _____ Zip _____

Phone _____ Email _____ Sex at birth (M/F) _____ Gender ID* _____ Race/ethnicity** _____

***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** (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, **W**-White/Caucasian.

Section 2: Adding dependents

LIST DEPENDENTS TO BE INSURED BELOW. Dependent enrollment must coincide with the time of student enrollment (with the exception of a newborn, placement of foster child, adopted child, or a qualifying event). Dependent coverage is available only if the student is also insured. The dependent's coverage period must match the insured's, and therefore, coverage will expire concurrently with the student's. Dependent coverage will end prior to that time if the dependent is no longer eligible under the plan.

Name (Last, first, MI)	**Sex assigned at birth**	**Gender identity***	**Birth date**	**Race/ ethnicity****
Spouse or domestic partner	☐ M ☐ F			
Dependent child	☐ M ☐ F			
Dependent child	☐ M ☐ F			
Dependent child	☐ M ☐ F			

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

Section 3: Other coverage

Health coverage 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(s) of individual(s) covered under the policy	Medical insurance carrier	Coverage dates	Will coverage continue?	Coverage type(s)
	Carrier name: Policy no.: Phone: Group name:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Pediatric dental ☐ Adult or family dental

Section 4: Payment information

The billed amount includes noninsured services, and certain federal, healthcare fees/assessments. Below, select your program. Please calculate total initial payment due by multiplying the monthly premium by the number of members enrolling. Please also select which type of program you are enrolling in. The premium for your enrollment period must be paid in full for coverage to be active. Coverage is effective the 1st of the month after we receive your enrollment application, except for September, which starts on the 11th.

Program: ☐ Postdoctoral fellow ☐ Vet residents ☐ Visiting scholar

	$276.00	per month, per member*
×	1	number of people enrolling
=	$ 276	total first month payment

*School administration fee of $17.50 per month will be billed directly to your student account by OSU.

Vet Residents, Visiting Scholars, Postdoctoral Fellows: We will mail an invoice to you monthly. The initial invoice from PacificSource will be sent within 10 days once the application is received. You can pay online via credit card or e-check through the PacificSource app, InTouch for Members. If you choose to pay by check, money order, or cashier's check, please reference the remittance details provided on your invoice.

If payment is not received with this application, you will have 30 days from the date signed to remit payment in full to PacificSource. Without payment within 30 days, PacificSource will cancel coverage. It is the student's responsibility for timely renewal payment whether or not a renewal notice is received. If you have questions, please call PacificSource Health Plans at **541-284-7961.**

Section 5: Payment

OPTION 1

1. Email this completed form to **MembershipStudentReps@PacificSource.com**.
2. Call **541-284-7961** to make a payment over the phone.
3. Or, wait until you receive information from us on how to pay.

OPTION 2

Mail check, money order, or cashier's check in U.S. dollars payable to PacificSource Health Plans and this enrollment form to:

PacificSource Health Plans
Attn: Membership Student Rep Team
PO Box 7068, Springfield, OR 97475

Section 6: 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 prorated 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, the premium will be returned, and any claims paid will need to be reimbursed; 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 its 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.

Student signature _____ **Date** _____
(or parent signature if student is under age 18)

Spouse/domestic partner signature _____ **Date** _____

Dependent signature _____ **Date** _____
(if age 18+ and enrolling for coverage)