Individual and Family Enrollment Form
State of Idaho Early Retirees

PacificSource HEALTH PLANS

Thank you for choosing PacificSource! What you'll need to complete this enrollment form:

- A blue or black pen (if you're not filling it out electronically).
- Information, such as your old ID card, from any insurance company that currently or recently covered you or your family. This information is needed to determine creditable coverage.
- Your health insurance broker's information, if applicable.
- The name of your primary care provider for all family members enrolling.

You are eligible to enroll if:

- You are under age 65 or otherwise not eligible for Medicare.
- You and your dependents (if enrolling) are not receiving benefits under Medicare Part A, Medicare Part B, nor enrolled in a Medicare Choice or Advantage plan.
- You are a resident of the state of Idaho, you do not have residency status in any other state, and can provide satisfactory proof of current Idaho residency. An individual who intends to reside in Idaho may submit an application for insurance but would not be eligible to begin coverage prior to the individual physically residing in Idaho.
- Your spouse/domestic partner (if applicable) is your legal spouse/domestic partner.
- Your children (if applicable) are your natural or adopted children, under age 26, or you are their legal guardian.
- Your employer will not be paying, or reimbursing you, for any part of the premium. You could receive reimbursement if your employer offers an individual coverage health reimbursement arrangement (ICHRA).

Need help?

If you have questions about any part of this enrollment form, we'd be happy to help. You can reach a PacificSource Coverage Advisor at **855-330-2792,** TTY: 711. We accept all relay calls.

What happens after you submit your application

We'll begin processing your application, and in the coming weeks, you'll receive a few things from us. To get information faster, include your email address in your application.

1. A Summary of Benefits and Coverage
2. New member information
3. Your ID card(s)
4. Your full policy

Please keep a copy of this application for your records.

1 What type of coverage would you like?

New Coverage

- ☐ For myself only
- ☐ For myself + my spouse/domestic partner
- ☐ For myself + my family

Or

Change to My Current Coverage

Current PacificSource ID No. _____
(This can be found on your ID card.)

- ☐ Add family member(s) (complete section 6)
- ☐ Change my plan as shown below

Enrolling due to ☐ Qualifying event (please explain below) ☐ The open enrollment period

Qualifying event _____

Date of retirement, if applicable _____/_____/_____

What date would you like the coverage to begin? _____/_____ Mo./Yr.

Documentation is required if enrolling outside of the open enrollment period, or adding dependents.

2 Choose a medical plan

For plan benefit information, please visit PacificSource.com or refer to our Idaho Individual and Family Plan brochure.

Navigator
Available statewide.

- ☐ Gold 2000
- ☐ Silver 3600
- ☐ Silver 6000
- ☐ Bronze HSA 6000
- ☐ Bronze HSA 8300
- ☐ Bronze HSA 10600

3 Choose a dental plan (If not enrolling in dental coverage, skip to next section.)

- ☐ Dental PPO 0-20-50 1000
- ☐ Dental PPO 0-20-50 1500
- ☐ Kids Dental PPO 0-20-50
  (coverage for members 18 and younger)

These policies include pediatric dental coverage that meets the requirements of the Affordable Care Act.

Enrolling myself and my family

List all family members you would like insured. Only your legal spouse, domestic partner, and dependent children are eligible. If a child is over the age of 26 and medically certified as disabled and dependent of parents, a copy of a certification is required.

*__Gender identity__ (optional): **NB**-Non-binary, **TM**-Trans man, **TW**-Trans 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.

***Use of tobacco on average four or more times per week within the past six months. Includes all tobacco products, except for religious or ceremonial use.

4 Applicant (required)

Name (First, MI, Last) _____

Sex assigned at birth (M/F) _____ Gender identity* _____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

Marital Status ☐ Single ☐ Married ☐ Domestic partnership

Physical address _____

City _____ State _____ Zip _____ County _____

Phone _____ Email _____

Mailing address (if different) _____

City _____ State _____ Zip _____

Primary care provider _____

Are you a current patient? ☐ Yes ☐ No

Do you use tobacco products?*** ☐ Yes ☐ No

If yes, is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

5 Spouse or domestic partner (Skip to section 6 if not enrolling a spouse or domestic partner.)

Name (First, MI, Last) _____

Sex assigned at birth (M/F) _____ Gender identity* _____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

Primary care provider _____

Are you a current patient? ☐ Yes ☐ No

Do you use tobacco products?*** ☐ Yes ☐ No

If yes, is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

6 Dependent child (Skip to section 7 if not enrolling dependents.)

Name (First, MI, Last) _____

Sex assigned at birth (M/F) _____ Gender identity* _____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

Primary care provider _____

Are you a current patient? ☐ Yes ☐ No

Do you use tobacco products?*** ☐ Yes ☐ No

If yes, is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Dependent child

Name (First, MI, Last) _____

Sex assigned at birth (M/F) _____ Gender identity* _____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

Primary care provider _____

Are you a current patient? ☐ Yes ☐ No

Do you use tobacco products?*** ☐ Yes ☐ No

If yes, is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Dependent child

Name (First, MI, Last) _____

Sex assigned at birth (M/F) _____ Gender identity* _____ Social Security No. _____

Race/ethnicity** _____ Date of birth (MM-DD-YY) _____

Primary care provider _____

Are you a current patient? ☐ Yes ☐ No

Do you use tobacco products?*** ☐ Yes ☐ No

If yes, is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Attach additional pages if needed. ☐ I have attached _____ pages

7 My other insurance information

Please list the most recent health or dental insurance coverage you or any family members listed on this form have had, including commercial (employer group or individual insurance), Medicaid, Medicare, Medicare Advantage, Medicare Supplemental, or pediatric dental coverage.

☐ No prior coverage

Name of other insurance company(ies) (include address and phone if available)

_____

Type of coverage (check all that apply)

☐ Medical ☐ Vision ☐ Pediatric dental ☐ Adult or family dental

Name(s) of individual(s) covered

_____

Date coverage began _____/_____/_____ Date coverage ended _____/_____/_____

Is coverage active? ☐ Yes ☐ No Policy no. _____

If group insurance, name of group _____

8 Certify, authorize, and sign

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

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 applicant 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 applicant. An enrollment form received by PacificSource requiring alterations will be modified by amendment and sent to the applicant for a signature. As the applicant, I understand I have the right to inspect the information in my file.

Electronic communications consent

By checking the "Yes" box on the next page, 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.

Your consent continues while the plan you enroll in is effective. You may, at any time, opt out of electronic communications by contacting the Customer Service team at **888-977-9299.** You may request a free paper copy of your application and/or enrollment information by contacting us via email at Individual@PacificSource.com, or by phone at **800-591-6579.** Electronic communications are offered as a convenience only. Your decision to not receive electronic communications will not affect your enrollment. There is no charge associated with switching to paper.

In order to complete the application electronically, you must have a personal computer or other device capable of accessing the internet and the ability to view and revise Portable Document Format (PDF) files. PacificSource may also send PDF documents to you as part of the application process. You can obtain a free copy of software to view PDF files at Get.Adobe.com/reader. PacificSource takes the security of electronic information and communications seriously. If you have any questions about our encryption, technical hardware or software, or our security policies and procedures, please contact us at Individual@PacificSource.com.

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

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

I (We) have reviewed and understand the authorization above.

Applicant:

Printed name _____

Signature _____ Date _____

If enrolling in coverage:

Spouse/domestic partner Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

This enrollment form must be signed and dated. All fields must be completed for this authorization to be valid. Once accepted, PacificSource will provide the policyholder with a copy of this completed form upon request.

9 Producer authorization (Skip to section 10 if you are not working with a producer.)

I, the insurance producer, have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the policy, except through written material furnished by PacificSource. The applicant has been informed that the effective date of coverage is assigned only by PacificSource. I hereby certify that information supplied to me by the applicant has been truly and accurately recorded hereon.

Applicant's name (printed) _____

Producer's name (printed) _____

PacificSource producer number _____

Producer's signature _____ Date _____

10 Premium payment authorization

- ☐ I authorize the Public Employee Retirement System of Idaho (PERSI) to pay PacificSource Health Plans for my monthly premium.
- ☐ I authorize PacificSource Health Plans and PERSI to exchange my address and enrollment information for purposes of administering this plan.
- ☐ I understand that payments will automatically be taken from the PERSI sick leave account or monthly pension check each month, and when these funds are exhausted, I may apply for a new policy directly with PacificSource.
- ☐ This authorization will remain in effect until termination by either party. If the individual policy premium changes, this authorization will automatically be adjusted to authorize withdrawal of an amount equal to the new premium.

Signature of applicant _____ Date _____

11 Are you ready to apply?

- ☐ Are all sections filled in completely?
- ☐ Have you attached requested paperwork?
- ☐ Did you select a policy coverage date on page 2?

Send your signed, completed enrollment form and attachments to us by:

Email: Individual@PacificSource.com
Fax: 541-225-3646
Mail: PacificSource Health Plans, PO Box 7068, Springfield, OR 97475-0068

Thank you for enrolling!