Employee Enrollment and Waiver Form

PacificSource HEALTH PLANS

Group Policy No. ______
Subgroup No. ______
Class No. or Plan ______
Are you an owner of this company? ☐ Yes ☐ No

Employer/Group Name ______ Effective Date ___/___/___ Date of Full-time Hire ___/___/___

Last Name ______ First Name ______ MI ______ Hours Worked per Week ______

Mailing Address ______ City ______ State ______ ZIP ______

Phone ______ Email ______

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership

By providing your email address, you are agreeing to receive email communications 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:^ ______

^Attach proof of event

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

Coverage		Name (Last, First, MI)	Gender	Birth Date	SSN	Race/ Ethnicity*	Primary Care Provider
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive ☐ Add ☐ Waive	Name: Employee	☐ M ☐ F ☐ X				
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive	Name: Spouse/Domestic Partner	☐ M ☐ F ☐ X				
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive	Name: Relationship to Employee:	☐ M ☐ F ☐ X				
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive	Name: Relationship to Employee:	☐ M ☐ F ☐ X				
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive	Name: Relationship to Employee:	☐ M ☐ F ☐ X				
☐ Medical ☐ Dental (not available in WA)	☐ Add ☐ Waive	Name: Relationship to Employee:	☐ M ☐ F ☐ X				

*Race/Ethnicity (Optional) Choose the code each member most closely identifies with: **AI**-American Indian/Alaska Native, **A-**Asian, **B-**Black/African American, **H-**Hispanic/Latino, **N-**Native Hawaiian/Other Pacific Islander, **W-**White/Caucasian

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	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 Waiver – If Employee is declining medical coverage.

☐ I have qualifying medical coverage through (list carrier name and check coverage type):

Name of Insurance Carrier ______________________________

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. Applies to Idaho, Oregon and Montana only.

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

Name of Insurance Carrier ______________________________

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 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 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**.

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

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:
    - Qualified sign language interpreters
    - 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:
    - Qualified interpreters
    - 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.

Amharic	ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (888) 977-9299 (መስማት ለተሳናቸው: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (888) 977-9299 (رقم هاتف الصم والبكم: 711).
Bantu	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (888) 977-9299 (TTY: 711).
Cambodian	បើ ប្រយ័ត្ន៖ សិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (888) 977-9299 (TTY: 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: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (888) 977-9299 (TTY: 711).
Nepali	ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःशुल्क 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	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با (888) 977-9299 (TTY: 711) تماس بگیرید.
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 jezičke pomoći dostupne su vam besplatno. Nazovite (888) 977-9299 (TTY–Telefon za osobe sa oštećenim 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).