

# Employee Enrollment and Waiver Form



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	Add Waive	Name:	M				
			F				
Dental (not available in WA)	Add Waive	Employee	X				
Medical	Add Waive	Name:	M				
			F				
Dental (not available in WA)	Add Waive	Spouse/Domestic Partner	X				
Medical	Add Waive	Name:	M				
			F				
Dental (not available in WA)	Add Waive	Relationship to Employee:	X				
Medical	Add Waive	Name:	M				
			F				
Dental (not available in WA)	Add Waive	Relationship to Employee:	X				
Medical	Add Waive	Name:	M				
			F				
Dental (not available in WA)	Add Waive	Relationship to Employee:	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 may 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



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, ໂດຍບໍ່ຄ່າຈ່າຍ, ຄຸນນະພາບພິເສດໃຫ້ທ່ານ. ໂທ (888) 977-9299 (TTY: 711).
Nepali	ध्यान दिनुहोस्: तपाइंले नेपाली बोल्नुहुन्छ भने तपाइंको नमिति भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (888) 977-9299 (टटिविडः 711) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistentsetjenester tilgjengelige for deg. Ring (888) 977-9299 (TTY: 711).
Pennsylvania Dutch	Wann du [Deutsch (Pennsylvania German/Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call (888) 977-9299 (TTY: 711).
Persian-Farsi	دش اب یم مهارف امش یارب ناگیار تروصب ینابز تالیست، دینک یم وگتفگ یسراف نابز م رگا: هجوت (888) 977-9299 (TTY: 711) دیریگب سامت
Punjabi	ਧਿਆਨ ਦਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵੱਚਿ 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).