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 toll-free **866-999-5583** (toll-free) to make your payment over the phone via credit card, or you can wait until you receive information from us 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. 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.

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 non-insured services, and certain federal, health care fees/assessments. Please use the tables below to calculate total amount due by selecting the box(es) next to the term(s) in which you are enrolling for coverage and entering how many people you are enrolling. Multiply that by the cost per term, per member. Please also select which type of student you are. The premium for your enrollment period must be paid in full for coverage to be active.

Program: ☐ Postdoctoral Fellow ☐ Vet Residents ☐ Visiting Scholar		**Number of Enrolling People**
Enrollment Deadline	Coverage is effective the 1st of the month after we receive your enrollment application.	
Coverage Dates	Coverage uses a standard monthly calendar, except for September. Coverage dates in September are 9/11 – 9/30. Fill in your desired coverage dates in a mm/dd/yr format using standard calendar dates. Desired coverage: _____	
Cost	$291.00 per month, per member*	

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 via credit card or e-check, through the PacificSource application Intouch for Members. If you choose to pay via 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 **866-999-5583.**

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

Section 5: Payment

OPTION 1

1. Email this completed form to **MembershipStudentReps@PacificSource.com**.
2. Call **866-999-5583** to make a credit card 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 Rep II 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 be effective 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, 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 **866-999-5583**. 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)

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, 711, 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, 888-779-9299, 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: የሚናገሩትቋንቋአማርኛከሆነየትርጉምእርዳታድርጅቶች፣በነጻሊያግዘዎትተዘጋጀተዋል፡ወደሚከተለውቁጥርይደውሉ888-977-9299(መስማትለተሳናቸው:711).
Arabic	املحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات املساعدة اللغوية تتوافر لك باملجان. 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)។

Amharic	ማስታወሻ: የሚናገሩትቋንቋአማርኛከሆነየትርጉምእርዳታድርጅቶች፣በነጻሊያግዝዎትተዘጋጀተዋል፡ወደሚከተለውቁጥርይደውሉ888-977-9299(መስማትለተሳናቸው: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 नमि्तभिाषा सहायता सेवाहरू नःिशुल्क 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).