Individual and Family Policy Enrollment Form
Washington

PacificSource HEALTH PLANS

Thank you for choosing PacificSource!
You may also enroll online at **PacificSource.com**.

Before you get started

What you'll need to complete this enrollment form:

- A blue or black pen.
- A copy of any documentation you may need to show legal guardianship.
- Your health insurance producer's information, if applicable.
- Your first month's premium payment (required before your policy will take effect).
- Proof of prior coverage if enrolling outside of the open enrollment timeframe. Please provide a certificate of creditable coverage and the prior coverage termination date.

You are eligible to enroll if:

- 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 Washington residing in Clark, Pierce, Spokane, and Thurston counties. An individual who intends to reside in Washington may submit an application for insurance but would not be eligible to begin coverage prior to the individual physically residing in Washington.
- Your spouse/domestic partner (if applicable) is your legal spouse/domestic partner.
- You or your legal spouse/domestic partner's children (if applicable) are your natural or adopted children, 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).

Please note: If you are eligible for federal financial assistance, you must apply for coverage through Washington Healthplanfinder at **wahealthplanfinder.org**.

Need help?

If you have questions about any part of this enrollment form, we'd be happy to help. You can reach us at **(855) 330-2792**.

What happens after you submit your application

We'll begin processing your application, and in the coming weeks, if you have met the qualifications and payment has been received, 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
- ☐ For my child(ren) or legal dependent(s) only

Or Change to My Current Coverage

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

- ☐ Add family member(s) (Complete section 5)
- ☐ Change my plan as shown below

Coverage effective dates

Enrolling due to ☐ Qualifying event (please explain below) ☐ The Open Enrollment Period

Qualifying Event _____ Date of Event _____/_____/_____

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. If you apply from November 1 through December 15, coverage will be effective January 1. If you apply from December 16 through January 15, coverage will be effective February 1.

2 Choose a medical plan

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

Navigator
Available in Clark, Pierce, Spokane, and Thurston counties.

- ☐ Bronze HSA 6900
- ☐ Bronze 7000
- ☐ Silver 5000
- ☐ Silver 3500
- ☐ Gold 2000

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 on parents, a copy of a certification is required.

Individual pediatric dental coverage is required for all dependents under 19 years of age

- ☐ I will purchase dental coverage from another insurance carrier. This selection requires you to complete the Attestation of Dental Coverage Form on page 9.
- ☐ I will not enroll any individual under age 19 on this plan.

3 Myself (required)

If this is a child/dependent only policy, PacificSource requires the responsible parent or guardian to include their information.

Name (First, MI, Last) _____

Gender (M/F) _____ 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 Name*** _____

Primary Care Provider Address*** _____

Are you a current patient? ☐ Yes ☐ No

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

Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

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

Name (First, MI, Last) _____

Gender (M/F) _____ Social Security No. _____

Race/Ethnicity* _____ Date of Birth (MM-DD-YY) _____

Primary Care Provider Name*** _____

Primary Care Provider Address*** _____

Are you a current patient? ☐ Yes ☐ No

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

Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

5 Dependent Child (Skip to section 6 if not enrolling dependents.)

Name (First, MI, Last) _____

Gender (M/F) _____ Social Security No. _____

Race/Ethnicity* _____ Date of Birth (MM-DD-YY) _____

Primary Care Provider Name*** _____

Primary Care Provider Address*** _____

Are you a current patient? ☐ Yes ☐ No

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

Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Dependent Child

Name (First, MI, Last) _____

Gender (M/F) _____ Social Security No. _____

Race/Ethnicity* _____ Date of Birth (MM-DD-YY) _____

Primary Care Provider Name*** _____

Primary Care Provider Address*** _____

Are you a current patient? ☐ Yes ☐ No

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

Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Dependent Child

Name (First, MI, Last) _____

Gender (M/F) _____ Social Security No. _____

Race/Ethnicity* _____ Date of Birth (MM-DD-YY) _____

Primary Care Provider Name*** _____

Primary Care Provider Address*** _____

Are you a current patient? ☐ Yes ☐ No

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

Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No

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

*__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.

*** Not required for plan enrollment. Used for coordinating care with member's dedicated care team.

6 My Other Insurance Information

Please list the most recent health or dental insurance coverage you, or any family members listed on this enrollment 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 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 _____

7 Certify, Authorize, and Sign

Be sure to sign and date the enrollment form on this and 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
It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

I affirm that the answers given in this enrollment form are complete and correct and, if this form includes 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. 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.

Electronic Communications Consent
By checking the "Yes" box at the top of 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 and termination of coverage.

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 Department 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 **(866) 695-8684**. 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 http://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: ☐ Yes ☐ No Email address _____

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

Enrollee/Responsible Party/Guardian Signature _____ Date _____

Printed Name _____ Relationship _____

If enrolling in coverage:

Spouse/Domestic Partner Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

Required if enrollee is a minor:

Printed name of ☐ Parent or ☐ Guardian _____

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 with the policy.

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

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

Enrollee's Name (printed) _____

Producer's Name (printed) _____

PacificSource Producer Number _____

Producer's Signature _____ Date _____

9 How do you prefer to pay for future premiums?

Your first month's premium must be received by check or money order before your policy will take effect. We will not accept third party payments except as required by federal law.

Please select your method of payment for future premium payments. Reminder: Your first month's premium can only be paid with a check or money order.

☐ Send me a paper bill by mail each month. *(Skip to section 10.)*

☐ Automatic withdrawal from my bank account, Electronic Funds Transfer (EFT). *The first month's payment cannot be made by EFT.*

We authorize and direct PacificSource Health Plans to withdraw funds as follows:

Amount of monthly withdrawal $_____ Withdrawals will occur on the 5th of each month.

Select one: ☐ Begin transfers on next available date ☐ Delay transfers until _____(Mo.)

Bank information

Bank Name _____

Account No. _____ Routing No. _____

Account Type

☐ Checking—attach a voided check ☐ Savings—attach a voided savings withdrawal slip

This authorization will remain in effect until termination by either party. If the individual policy premium changes due to a rate increase, alternate plan selection, or age change of the policyholder, this authorization will automatically be amended to authorize withdrawal of an amount equal to the new premium.

Policyholder's Name (printed) _____ Date _____

Signature of Bank Account Holder _____ Date _____

Important details about the automatic withdrawal of your monthly premiums:

- New accounts may take 30 days to set up. If your policy is accepted and coverage starts sooner than your automatic withdrawal is set up, you may need to pay by check until the funds transfer is in place.
- Transfers occur on the 5th of each month. If the 5th falls on a weekend or a holiday, the transfer will occur on the next business day.
- Transfers will be made for the premium balance due.
- If EFT is not set up prior to the bill date of the second month, you may receive a paper bill for the second month.

10 Are You Ready to Submit?

☐ Are all sections filled in completely?
☐ Have you attached requested paperwork (i.e., guardianship documentation, etc.)?
☐ Did you select a policy coverage date on page 2?
☐ Have you included a check or money order for your first month's premium payment?
☐ Have you selected an ongoing payment option and attached a voided check if needed? (See section 9)

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!

Washington law (RCW 48.43.510) requires an offer of certain health plan information before purchase or selection of a health plan. You can review that information at **PacificSource.com** or request from our Customer Service Department **888-977-9299**. Available information concerns benefits, required preauthorizations, premiums and cost sharing, in-network providers, appeals and grievances, accreditation, and confidentiality. If you wish to purchase coverage through the Health Benefit Exchange, you must apply directly through them.

Attestation of Dental Coverage Form (your proof)

Complete and sign the form below, and then send a copy to us along with a copy of the proof from your insurance carrier. PacificSource must receive, within 60 days, reasonable assurance that you (the applicant) obtained or will obtain pediatric dental benefits through a stand-alone Qualified Dental Plan (QDP) per WAC 284-43-5760(1)(b).

Member Name (First, MI, Last) _____

Street Address _____

City _____ State _____ ZIP _____

Member ID Number _____

Name of Dental Carrier _____

Effective Date of Dental Policy _____

Covered Members on the Dental Policy:

_____

_____

_____

Signature _____ Date _____

For assistance in a language other than English, please call us at (888) 977-9299. For TTY, please call (800) 735-2900 or 711.

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 Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia linguística. Llame al (888) 977-9299.

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。

Discrimination Is Against the Law

PacificSource 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) 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.

Arabic	بخصوص PacificSource Health Plans ، فلديك الحق في الحصول على المساعدة والمعلومات تتكلفة. للتحدث مع مترجم اتصل بـ (888) 977-9299. إن كان لديك أو لدى شخص تساعده أسئلة الضرورية بلغتك من دون اية
Cambodian-Mon-Khmer	បុរសិនបរេើអុនក ឬនរណាមុនន ក់ដលែអុនកកំពុងដជ្ជួយ មុននសំណួ រអុំពី PacificSource Health Plans បរ, អុនកមុននសិធេិរ្ជួលជំនួយនិងព័ត៌មុនន បរៅកនុងភាសា រស់អុនក បរោយមិនអុស់ហ្ញាក់ ។ បរើែមបីនិយាយជាមួយអុនករកដបុរ សូម (888) 977-9299.
Chinese	如果您，或是您正在協助的對象，有關於[插入 SBM 項目的名稱 PacificSource Health Plans 方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話［在此插入數字 (888) 977-9299.
Cushite-Oromo	Isin yookan namni biraa isin deeggartan PacificSource Health Plans irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta’een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa (888) 977-9299 tiin bilbilaa.

Arabic	بخصوص PacificSource Health Plans ، فلديك الحق في الحصول على المساعدة والمعلومات تتكلفة. للتحدث مع مترجم اتصل بـ 977-9299 (888). إن كان لديك أو لدى شخص تساعده أسئلة الضرورية بلغتك من دون اية
French	Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de PacificSource Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (888) 977-9299.
German	Falls Sie oder jemand, dem Sie helfen, Fragen zum PacificSource Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (888) 977-9299 an.
Japanese	ご本人様、またはお客様の身の回りの方でもPacificSource Health Plans についてご質問がございました ら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。 通訳とお話される場合、(888) 977-9299までお電話ください。
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 PacificSource Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (888) 977-9299로 전화하십시오.
Persian-Farsi	میکنید ، سوال در مورد PacificSource Health Plans ، داشته باشید حق این را دارید که کمک دریافت نمایید.977-9299 (888) تماس حاصل نمایید. اگر شما، یا کسی که شما به او کمک و اطلاعات به زبان خود را به طور رایگان
Romanian	Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind PacificSource Health Plans, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la (888) 977-9299.
Russian	1Если у вас или лица, которому вы помогаете, имеются вопросы по поводу PacificSource Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (888) 977-9299.
Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de PacificSource Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (888) 977-9299.
Thai	หากคณุ หรือคนทีคณก าลงช่วยเหลือมีค าถามเกียวกบั PacificSource Health Plans คณมีสิทธิทีจะได้รับความช่วยเหลือและข้อมลในภาษาของคณได้โดยไม่มีค่าใช้จ่าย พดคยุ กบลาม โทร (888) 977-9299.
Ukrainian	Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про PacificSource Health Plans, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на (888) 977-9299.
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về PacificSource Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (888) 977-9299.