



Medical Dual Option and Dental Enrollment Application and Change of Information Form

Enrolled online _____ Date _____

* Group/Employer _____		Group Number (Complete if known): _____		Division Number or Name (Complete if known): _____	
* Coverage: <input type="checkbox"/> Dental Coverage <input type="checkbox"/> Medical Coverage <input type="checkbox"/> PPO <input type="checkbox"/> HSA	Type of Application <input type="checkbox"/> New Enrollment or Rehire Effective Date: _____ <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA/Continuation COBRA/Continuation (not for current employees) COBRA Qualifying Events: <input type="checkbox"/> Divorce <input type="checkbox"/> End of employment <input type="checkbox"/> Reduction in hours <input type="checkbox"/> Loss of dependent child status <input type="checkbox"/> Other _____ Event Date: _____	Changes <input type="checkbox"/> Address Change <input type="checkbox"/> Primary Care Physician Change Effective Date: _____ <input type="checkbox"/> Name Change Effective Date: _____ New Name: _____ Old Name: _____	<input type="checkbox"/> Add Dependent(s) - List Dependent(s) to add in dependent section and qualifying event date*: Newborn Birth Date: _____ Adoption Date: _____ Marriage Date: _____ Court Appointed Guardian Date: _____ Loss of Group Coverage Date: _____ Returned to Full-Time Student Status Date: _____ <small>*Dependent adds require a qualifying event date unless added during open enrollment.</small>	<input type="checkbox"/> Terminate Dependent(s) - List Dependent(s) being terminated in dependent section, date and reason. Termination Date: _____ Reason: _____	

Please complete this form and sign on the back. Please type or print legibly in ink. Thank you!

* Employee First Name	M.I.	* Last	* Birth date	* Date of Employment mm/dd/yy	* Employee Social Security #
* Employee Mailing Address					* Home Phone Number
				()	

* Name First	M.I.	* Last	* Birth date	* Gender	* Relationship (Spouse, Child, Ward, etc.)	Is this dependent a full-time college student?	If yes, school name
_____		_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	Self	_____	_____
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	

Other Insurance (Coordination of Benefits)

Will employee or any dependents have **other** insurance? Dental No Other Dental Insurance Medical No Other Medical Insurance

OVER ⇄⇄⇄

* Enrollment will be delayed if fields noted in red or with an asterisk are not filled out.

ODS Enrollment Application

It is VERY important that the employee sign and date below. Thank you!

Pre-existing Condition Exclusion (For Members enrolling in Medical Plan)

Were you or any of your dependents covered through another group or individual plan at any time during the past 63 days before your enrollment date on this plan?

- No
- Yes. If yes, please attach your Certificate of Credible Coverage from your current or prior health plan. A pre-existing period may be reduced by any prior creditable health coverage.

Covered Dependent Children Definition

An unmarried child is eligible for coverage if he/she meets the dependent eligibility requirements of the employees plan. See your Member Handbook for details.

The following are eligible dependent children:

- Your natural child
- Your step-child or adopted child
- Children placed with you for adoption
- Newborns born to a covered dependent, for whom you are financially responsible (legal guardianship is required for coverage after the first 31 days)
- Children related by blood or marriage for whom you are the legal guardian (You will need to attach a signed court order showing legal guardianship)
- Your domestic partner's child or adopted child (if applicable to your employer plan)

Please read and sign below.

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.* Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all the red fields are not filled out entirely.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 503-243-4492.

REQUIRED

* X

* Date: