



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

Enrolled online \_\_\_\_\_ Date \_\_\_\_\_

\* Group/Employer: \_\_\_\_\_ \* Group ID: \_\_\_\_\_ \* Subgroup ID or Name: \_\_\_\_\_ \* Class: \_\_\_\_\_

<p><b>* Coverage:</b></p> <p><input type="checkbox"/> <b>Dental Coverage</b></p> <p><input type="checkbox"/> ODS Dental</p> <p><input type="checkbox"/> DirectOption (Willamette Dental)</p> <p><input type="checkbox"/> <b>Medical Coverage</b></p> <p><input type="checkbox"/> Indemnity or PPO (No PCP needed)</p> <p><input type="checkbox"/> Point of Service (Select a PCP)</p> <p><input type="checkbox"/> Managed Care (Select a PCP)</p>	<p><b>Type of Application</b></p> <p><input type="checkbox"/> <b>New Enrollment</b>   <input type="checkbox"/> <b>Rehire</b></p> <p>Effective Date: _____</p> <p><input type="checkbox"/> <b>Open Enrollment</b> _____</p> <hr/> <p><input type="checkbox"/> <b>COBRA/Continuation</b> COBRA/Continuation (not for current employees)</p> <p><b>COBRA Qualifying Events:</b></p> <p><input type="checkbox"/> Divorce   <input type="checkbox"/> End of employment</p> <p><input type="checkbox"/> Reduction in hours   <input type="checkbox"/> Loss of dependent child status</p> <p><input type="checkbox"/> Other _____ Event Date: _____</p>	<p><b>Changes</b></p> <p><input type="checkbox"/> <b>Address Change</b></p> <p><input type="checkbox"/> <b>Primary Care Physician Change</b></p> <p>Effective Date: _____</p> <p><input type="checkbox"/> <b>Name Change</b></p> <p>New Name: _____</p>	<p><input type="checkbox"/> <b>Add Member(s)</b> - List Member(s) to add in member section and qualifying event date*.</p> <p>Newborn Birth Date: _____</p> <p>Adoption Date: _____</p> <p>Marriage Date: _____</p> <p>(marriage certificate required with enrollment)</p> <p>Domestic Partnership Affidavit Date: _____</p> <p><small>Only if applicable to your plan</small> (Domestic Partner Affidavit required with enrollment)</p> <p>Court Appointed Guardian Date: _____</p> <p>Loss of Group Coverage Date: _____</p> <p>(CCC required with enrollment)</p> <p>Returned to Full-Time Student Status Date: _____</p> <p>*Member adds require a qualifying event date unless added during open enrollment.</p>	<p><input type="checkbox"/> <b>Terminate member(s)</b> - List Member(s) being terminated in member section, date and reason.</p> <p>Termination Date: _____</p> <p>Reason: _____</p>
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**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				* City	* State	* Zip
				Home Phone Number		
				(   )		

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

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.

*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.*

**\* X**

*(Signature required before enrollment can be processed)*

**\* Date:**

www.odscompanies.com