



# Enrollment Application and Change of Information Form

Please complete both sides of this form and sign on the back. Please type or print legibly in black or blue ink. Thank you!

<b>Applicant Name</b>			Birthdate	Gender	Applicant SS Number
First	M.I.	Last		<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Applicant Mailing Address</b>					Home Phone Number
Address			City	State	ZIP
					( )

<b>Marital Status</b>	<b>Prior Employer and Division</b>	<b>Prior Plan No.</b>	<b>Prior Member No.</b>
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <i>(Complete if known)</i>		

Dependent Information (If terminating dependents, please list those dependents to remove from coverage.)

Name	Birthdate	Gender	Relationship
First			
Subscriber	_____	<input type="checkbox"/> M <input type="checkbox"/> F	Self
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	

Will you or any dependents have **other** health insurance?  Y  N Are you or any dependents currently eligible for Medicare coverage?  Y  N If yes, please indicate:

Insured Employee	Insured Dependents	Insured Company	Group No.	Subscriber	Effective Date

**Coverage** (Please choose the Prevailing Plan or the Low Cost Plan.)

Preferred PPO

Prevailing Plan

Low Cost Plan

**Type of Application**

New Enrollment  
Date of Employment: \_\_\_\_\_  
Effective Date: \_\_\_\_\_

Changes:

Address Change  
*(complete address section)*

Name Change  
Effective Date: \_\_\_\_\_  
New Name: \_\_\_\_\_  
Old Name: \_\_\_\_\_

Add Dependent(s) - List dependent(s) to add in dependent section and qualifying event date\*.  
Newborn Birthdate: \_\_\_\_\_  
Adoption Date: \_\_\_\_\_  
Marriage Date: \_\_\_\_\_  
Court-Appointed Guardian Date: \_\_\_\_\_

\* Dependent adds require a qualifying event date.

Terminate Dependent(s) - List dependent(s) being terminated in dependent section, date and reason.  
Term. Date: \_\_\_\_\_  
Reason: \_\_\_\_\_

OVER



# ODS Enrollment Application

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

## Out-of-Area Dependent Children and Full-time Students

Complete this section if you have eligible dependents who do not permanently reside with you or who attend an accredited school or college university on a **full-time basis**.

<u>Dependent Name</u>	<u>Home ZIP Code</u>	<u>Full Time</u>	<u>School Name</u>
_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	_____

## Covered Dependent Children Definition

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

**The following are eligible dependent children:**

- Your natural child
- Your step-child, adopted child or a child placed with you for adoption
- Newborns born to a covered dependent (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)

### 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 healthcare treatment, payment or for the purpose of business operations necessary to administer healthcare 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 healthcare 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.

REQUIRED

→ X

## Portability Eligibility Requirements

You are eligible for portability coverage under this agreement if you meet the following requirements:

- You have been continuously covered (not counting any required employment probationary period prior to coverage) for 180 days or more under one or more Oregon Group health benefit plans, or you meet the eligibility requirements of the Health Insurance Portability and Accountability Act of 1998;
- You have applied for portability coverage no later than the 63rd day after termination of your prior coverage;
- You are not eligible for prior group coverage or would remain eligible for prior group coverage under the Federal Employee Retirement Income Security Act of 1974, as amended, were it not for action by the plan sponsor relating to the actual or expected health condition of the individual;
- You are not covered under another health benefit plan at the time that portability coverage would commence;
- You are not eligible for the federal Medicare program; and
- You are an Oregon resident.

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.

Date \_\_\_\_\_