



Portability PPO Enrollment Application and Change of Information Form

Mail completed application to:
ODS
Attn: Eligibility Department
601 SW Second Ave., Ste. 900
Portland, OR 97204

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

* Applicant First Name	M.I.	* Last	* Birth date	* Gender	* Applicant's Social Security #
* Applicant Mailing Address	* City	* State	* Zip	Home Phone Number	
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* Coverage: PPO <input type="checkbox"/> Prevailing Plan <input type="checkbox"/> Low-cost Plan	Type of Application <input type="checkbox"/> New Enrollment Date of Group Plan Termination: _____ Effective Date for Portability Plan: _____	Changes <input type="checkbox"/> Name Change Effective Date: _____ New Name: _____ Old Name: _____		<input type="checkbox"/> Terminate Dependent(s) - List Dependent(s) being terminated in dependent section, date and reason. Termination Date: _____ Reason: _____
		<input type="checkbox"/> Address Change		

Dependent information (Please list below only the dependents for whom you would like to continue coverage.)

* Name First	M.I.	* Last	* Birth date	* Gender	* Relationship	Social Security Number
					<input type="checkbox"/> Spouse <input type="checkbox"/> DP	
					Child	
					Child	
					Child	
					<input type="checkbox"/> Child <input type="checkbox"/> Ward	

* Relationship code: DP = Domestic Partner

Other Insurance (Coordination of Benefits)

Will applicant or any dependents have other insurance?	<input type="checkbox"/> Dental	<input type="checkbox"/> No Other Dental Insurance	<input type="checkbox"/> Medical	<input type="checkbox"/> No Other Medical Insurance
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It is VERY important that the applicant sign and date below. Thank you!

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**

*** Date:** _____

Portability Billing Information

You must return the correct premium payment with the portability application. To calculate your correct amount, please refer to the enclosed brochure.

If your group coverage has already ended, you must include payment from the first day of the month following termination of your group coverage.

Please indicate your preferred billing option:

- Monthly electronic funds transfer (by checking account deduction only)**
(If you select this option, please attach a voided check along with a check for the first month's premium amount. If your group coverage was terminated within the last 63 days, you must also include payment for any prior month's premium amount. You must complete the electronic deduction authorization below.)
- Monthly billing statement (Attach a check for the correct premium.)**
Please make checks payable to ODS Health Plans, Inc.

Authorization Agreement for Electronic Deduction

Instructions:

1. Complete and sign the Authorization Agreement for monthly automatic bank deduction of insurance premium
2. Attach a "VOID" sample of your check, in addition to a check for your first month's premium amount.
3. Submit the completed application and appropriate documents with your application.

Name of Applicant: _____

Name of Account Holder: _____

I (or we if this is a joint account) authorize ODS to charge my (our) checking account for monthly insurance premiums for the above named individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Name of Bank: _____

Signature of Account Holder: _____ Date: _____

You may be billed for the premium payment necessary to begin electronic deductions. If you wish to cancel your bank deductions, we must receive written notice 15 days before the next deduction date.

* Sending in a check does not guarantee coverage. Your premium payment will not be credited to your account until your application for Portability health insurance coverage has been approved by ODS. You will be notified in writing of your application status no later than 60 days from receipt. If your application is approved, the coverage effective date will be the 1st day of the month after termination of your group coverage. If your application is not approved, you will be notified in writing, and your check will be returned to you.

REQUIRED