

**GROUP HEALTH
ENROLLMENT
APPLICATION**



PO Box 7068 • Eugene, OR 97401
(541) 684-5583 or (866) 999-5583
Membership Fax (541) 225-3642
Marketing Fax (541) 225-3645
www.pacificsource.com

Please write legibly in black or blue ink. Complete all applicable sections.

| | |
|-------------------------------------|--|
| Group Policy No. G0020720 | Subgroup-Class / Plan Selection HIP Plan: <input type="checkbox"/> P001-1001 HIP Employee <input type="checkbox"/> P001-7001 HIP Retiree <input type="checkbox"/> P001-9001 HIPCOBRA PPO Plan: <input type="checkbox"/> P002-1002 PPO Employee: <input type="checkbox"/> P002-7002 PPO Retiree <input type="checkbox"/> P002-9002 PPO COBRA |
|-------------------------------------|--|

Section 1 – Employer Information

| | |
|--|---|
| Employer/Group Name CITY OF SPRINGFIELD- OPEN ENROLLMENT | Effective Date month <u>Jan</u> day <u>01</u> year <u>2011</u> |
| Date of Full Time Hire (required) month _____ day _____ year _____ | Number of Hours Work Per Week _____ |
| Employment Status <input checked="" type="checkbox"/> Active <input type="checkbox"/> Other _____ | |

Section 2 – Employee Information

| | | |
|---|---|---|
| Employee Last Name | First Name | M.I. |
| Mailing Address | | |
| City | State | Zip code |
| Home Phone No. | E-Mail Address | Job Title |
| Date of Birth month _____ day _____ year _____ | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Registered Domestic Partner |
| Type: <input type="checkbox"/> New Applicant–Employee <input checked="" type="checkbox"/> Add dependents <input type="checkbox"/> COBRA or Continuation qualifying event _____ Due To: <input type="checkbox"/> New Hire <input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Registration <input type="checkbox"/> Birth <input type="checkbox"/> Adoption* <input type="checkbox"/> Court Order* <input type="checkbox"/> Involuntary loss of other coverage* Date Qualifying Event Occurred: month _____ day _____ year _____ *Attach proof of qualifying event | | |

Section 3 – Family Information

Complete for yourself and each family member you wish to enroll.

| Name | Sex | Birth Date | Social Security Number (Required–refer to disclosure) |
|--------------------------------------|-----|------------|--|
| Employee | | | |
| Spouse / Registered Domestic Partner | | | |
| Child | | | |

Your relationship to any family member above with a different last name: _____

Name of full time student (12+ credits) over age 18 and name of school: _____

Primary language spoken in household: English Español Other: _____

Para asistirle en español, por favor llame al numero (800) 624-6052, ext. 1009, de Lunes a Viernes, 8:00 a.m. hasta 5:00 p.m.

Section 4 – Other Coverage

Current or Prior Coverage Information – Do you or any person listed on this application have or have had health insurance in the last 24 months? No Yes If yes, complete the following **and** attach proof with dates of coverage.

| Name | Insurance Carrier | Date of coverage | Will Coverage Continue? | Type of Coverage |
|------|--|------------------|---|--|
| | Carrier Name: Policy No.: Phone No.: | Begin: End: | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree |
| | Carrier Name: Policy No.: Phone No.: | Begin: End: | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree |
| | Carrier Name: Policy No.: Phone No.: | Begin: End: | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree |

Married or registered – Is your spouse or domestic partner employed? No Yes If yes, self employed? No Yes

Medicare – If you or any person on this application have Medicare, is coverage? Part A Part B Part D

| Name | Original Effective Date | Medicare No. (include alpha prefix) | Reason for Medicare Entitlement |
|------|-------------------------|-------------------------------------|---|
| | | | <input type="checkbox"/> Age <input type="checkbox"/> ERSD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement |
| | | | <input type="checkbox"/> Age <input type="checkbox"/> ERSD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement |

Section 5 – Child Custody Information

If you are enrolling children of a previous relationship, you must complete this section. List court ordered coverage in Section 4 above. Oregon law requires PacificSource to provide plan information to the custodial parent.

| Child's Name | Whose Child | Joint Custody | Custodial Parent Name | Custodial Parent Address | Custodial Parent Phone No. | If Court Order, Name Responsible for Insurance |
|--------------|---|---|-----------------------|--------------------------|----------------------------|--|
| | <input type="checkbox"/> Yours <input type="checkbox"/> Spouse | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | <input type="checkbox"/> Yours <input type="checkbox"/> Spouse | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | <input type="checkbox"/> Yours <input type="checkbox"/> Spouse | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

Section 6 – Acknowledgement and Declaration

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating health care treatment, payment, or for 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 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.

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 psychotherapy notes.

A separate authorization will be used for this information.

I affirm that the answers given in this application are complete and correct.

Employee Signature

Date

Instructions

This enrollment application contains two parts: the Disclosures Section and the Enrollment Information Section.

- **Read the Disclosures Section carefully.** This information will help you understand certain requirements of your employer's health plan.
- **Detach the Disclosures page** and save it for future reference.
- **Complete the Enrollment Information Section.** Be sure to answer everything in this application that applies to you. It is important that you provide all requested information so your benefits can be administered correctly.
- **Please be sure to sign and date the form.**
- **Return the Enrollment Information page to your plan administrator.**

Disclosures Section

Social Security Numbers – Guidelines for Section 3

A new Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers to report information that the Secretary of the Department of Health and Human Services requires for purposes of coordination of benefits. In order for Medicare to coordinate Medicare payments with other insurance benefits properly, Medicare relies on the collection of both the Social Security Number (or Medicare Health Insurance Claim Numbers) and the Employer Identification Number. Therefore, please provide Social Security Numbers for each family member listed.

Exclusion Periods – Guidelines for Section 4

What conditions have exclusion periods and how long are they? The plan excludes coverage for organ transplants and any related services for 24 months. Your plan also excludes coverage for elective procedures, surgery for ear infections, removal of tonsils or adenoids, and sterilization for six months.

If I had prior health coverage, will my exclusion periods be shortened or eliminated? You can receive credit toward this plan's exclusion periods if you had qualifying healthcare coverage before enrolling in this plan. To qualify for this credit, there may not have been more than a 63-day gap between your last day of coverage under the previous health plan and your first day of coverage (or the first day of your employer's eligibility waiting/probationary period) under this plan. Also, your prior coverage must have been a group health plan, COBRA or state continuation, individual health insurance policy (including student health plans), Medicaid, Medicare, TRICARE, State Children's Health Insurance Program, and coverage through risk pools and the Peace Corps. If you were covered as a dependent under a plan that meets these qualifications, you will qualify for credit. Many people elect the COBRA or state continuation coverage available under a prior plan to make sure they won't have more than a 63-day gap in coverage.

It is your responsibility to show us you had creditable coverage in writing. If you qualify for credit, we will count every day of coverage under your prior plan toward this plan's exclusion periods for pre-existing conditions, other specified conditions, and transplants.

How can I prove my prior creditable coverage? You can show evidence of creditable coverage by sending us a Certificate of Creditable Coverage from your previous health plan. All health plans, insurance companies, and HMOs are required by law to provide these certificates on request, and most issue these certificates automatically whenever someone's coverage ends. The certificate shows how long you were covered under your previous plan and when your coverage ended.

If you do not have a certificate of prior coverage, contact your previous insurance company or plan sponsor (such as your former employer, if you had a group health plan). You have the right to request a certificate from any prior plan, insurer, HMO, or other entity through which you had creditable coverage. If you are unable to obtain a certificate, please contact the PacificSource Membership Department at (541) 684-5583 or (866) 999-5583 and we will assist you.

Example of how your plan's exclusion period rules work. Mike worked at Oldco, and was covered under Oldco's group health plan for five months. He did not have any health coverage before his Oldco group plan.

Mike quit his job at Oldco and did not elect the COBRA continuation coverage. Exactly 60 days after quitting his job at Oldco, Mike was hired for a full time, benefits eligible job at Newco. Newco has a PacificSource group health plan with the same exclusion periods and rules as your employer's plan. Mike enrolled in Newco's group plan as soon as he satisfied Newco's eligibility waiting/probationary period.

- Mike will receive credit for the Oldco coverage because the gap between his last day under the Oldco plan and his hire date at Newco was less than 63 days.

- Mike will receive five months of prior coverage credit for the Oldco plan, so his pre-existing conditions exclusion period is reduced to one month. That one-month period begins on his enrollment date (after he satisfies Newco's eligibility waiting/probationary period).
- Mike's pre-existing conditions look back period is the six months ending on his hire date.
- The other specified conditions (elective procedures, surgery for ear infections, removal of tonsils or adenoids, and sterilization) are also excluded for one month, and transplants are excluded for 19 months (24 months reduced by five months of prior coverage credit).

Special Enrollment Rights

The PacificSource group health plan offered by your employer contains provisions that, in certain situations, may allow you or your family members to enroll in the plan later if you decline enrollment when you are first eligible. These special enrollment rights affect both you and your eligible family members.

The agreement between PacificSource and your employer may require all eligible employees to participate in the group health plan. In that case, you must enroll in the plan when you first become eligible. However, your family members may decline coverage, and they may enroll in the plan later if they qualify under Rule #1 or Rule #2 below.

Some employers have agreements with PacificSource allowing employees with other group health coverage to waive the PacificSource group coverage. In that case, both you and your family members may decline coverage when you are eligible. You and your family members may enroll in the plan later if you qualify under Rule #1 or Rule #2 below and a "Waiver of Coverage" form was submitted to PacificSource during your initial enrollment period or at the time you disenrolled in the group plan (see Waiving Health Coverage below).

Special Enrollment Rule #1

If you decline enrollment for yourself or your dependents (including your spouse or registered domestic partner) because of other group health insurance coverage, you or your family members may enroll in the plan later if the other coverage ends involuntarily. "Involuntarily" means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, the other insurance plan was discontinued or the maximum lifetime benefit of the other plan was exhausted, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation. To do so, you must request enrollment within 31 days after your other group health insurance coverage ends.

Special Enrollment Rule #2

If you acquire new dependents because of marriage, registration of domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your new dependents at that time. To do so, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rule #3

If you acquire new dependents because of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new dependents at that time. To do so, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

For more information on your plan's special enrollment provisions, please refer to your Member Benefit Handbook or contact the PacificSource Customer Service Department at (541) 684-5582 or (888) 977-9299.