

City of Springfield Group Health Plan Enrollment Application

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

Enrollment Information

G0020720	Subgroup/Class No:	<u>AFSCME</u>	<u>IAFF</u>	<u>Non-Rep</u>	<u>SEIU/OPEU</u>	<u>SPA</u>
	HIP: Active	<input type="checkbox"/> P001-1101	<input type="checkbox"/> P006-1201	<input type="checkbox"/> P006-1301	<input type="checkbox"/> P006-1401	<input type="checkbox"/> P001-1501
	Retiree	<input type="checkbox"/> P004-7101	<input type="checkbox"/> P004-7201	<input type="checkbox"/> P004-7301	<input type="checkbox"/> P004-7401	<input type="checkbox"/> P004-7501
COBRA	<input type="checkbox"/> P005-9101	<input type="checkbox"/> P005-9201	<input type="checkbox"/> P005-9301	<input type="checkbox"/> P005-9401	<input type="checkbox"/> P005-9501	
PPO: Active	<input type="checkbox"/> P002-1102	<input type="checkbox"/> P006-1202	<input type="checkbox"/> P006-1302	<input type="checkbox"/> P006-1402	<input type="checkbox"/> P002-1502	
Retiree	<input type="checkbox"/> P004-7102	<input type="checkbox"/> P004-7202	<input type="checkbox"/> P004-7302	<input type="checkbox"/> P004-7402	<input type="checkbox"/> P004-7502	
COBRA	<input type="checkbox"/> P005-9102	<input type="checkbox"/> P005-9202	<input type="checkbox"/> P005-9302	<input type="checkbox"/> P005-9402	<input type="checkbox"/> P005-9502	

Date of Full Time Hire (required) month _____ day _____ year _____	Number of Hours Worked Per Week	Effective Date month _____ day _____ year _____
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Employee Information

Employee Last Name	First Name	M.I.
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Mailing Address	City	State	ZIP code
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Home Phone No.	Email Address	Job Title
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Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner—If checked, are you registered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, State: _____
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Are you an active employee? Yes No If yes, complete Section 2A. If no, complete Section 2B.

Section 2A – Type of New Enrollment I am <input type="checkbox"/> New Employee <input type="checkbox"/> Adding dependent spouse, partner, or child Date of qualifying event: _____ <i>Attach proof of event</i> <input type="checkbox"/> New Hire <input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Registration or Affidavit <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Court Order <input type="checkbox"/> Involuntary loss of other group coverage <input type="checkbox"/> Late Enrollment or Open Enrollment (<i>see disclosure for information</i>)	Section 2B – Continuation of Coverage I am eligible for <input type="checkbox"/> COBRA Date of qualifying event: _____ <input type="checkbox"/> Termination of employment or reduced hours <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Death of employee <input type="checkbox"/> Dependent no longer meets eligibility
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Employee and Family Members You Wish to Enroll

Ethnicity/Race Code (choose the code each family member would most closely identify with): **A**IAN-American Indian/Alaska Native, **A**-Asian, **B**-Black/African American, **H**-Hispanic/Latino, **N**-Native Hawaiian/Other Pacific Islander, **W**-White/Caucasian

Name	Sex	Birth Date	Social Security Number— Required Section 111 of Public Law 110-173	Ethnicity /Race
Employee				
Spouse or Domestic Partner				
Dependent Child				

If you or your spouse/domestic partner are a **court-ordered guardian** of any dependent listed above, identify and provide proof:
 Name(s): _____ Grandchild Niece/Nephew Sibling Foster Other: _____

Primary language spoken in household: English Español Other: _____
Para asistirle en español, por favor llame al número (800) 624-6052, ext. 1009, de Lunes a Viernes, 7:00 a.m. hasta 5:00 p.m

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(s)	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"/> Dental <input type="checkbox"/> Medical <input type="checkbox"/> Vision
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dental <input type="checkbox"/> Medical <input type="checkbox"/> Vision
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dental <input type="checkbox"/> Medical <input type="checkbox"/> Vision

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

Medicare – If you or any person on this application has Medicare, indicate 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"/> ESRD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement
			<input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement

Child Custody Information

If you are enrolling children of a previous relationship, you must complete this section. Also, list court ordered coverage in Other Coverage section 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.	Name Responsible for Insurance (court order)
	<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				

Acknowledgement and Declaration

I acknowledge and understand that my Plan Sponsor or Plan Administrator 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 or dental 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. I, the applicant, authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group contract.

Employee Signature: _____ **Date:** _____

City of Springfield Group Health Plan Enrollment Application

Detach and keep
for your records.

This enrollment application contains two parts: the enrollment form (pages 1–2) and information (page 3)

- **Please read the information pages carefully** to help you understand requirements of your employer's health plan.
- **Complete the enrollment form.** Be sure to answer everything that applies to you.
- **Sign and date the form.**
- **Detach the information pages and make a copy of the form.** Keep these pages with your own insurance records.
- **Return the original, completed form to your employer.**

Employee and Family Members You Wish to Enroll

Dependents – Dependents of a covered employee who meet one of the following requirements may also be eligible for enrollment.

- Your legal spouse or qualified domestic partner.
- Your, your spouse's, or your qualified domestic partner's dependent children or foster child under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your spouse's, or your qualified domestic partner's unmarried dependent children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage.
- Your sibling, niece, nephew, or grandchild under age 19 who is unmarried, or not in a qualified domestic partnership, who is related to you by blood, marriage, or qualified domestic partnership AND for whom you are the court appointed legal custodian or guardian with the expectation that the family member will live in your household for at least a year.
- A child placed for adoption with you, your spouse, or qualified domestic partner. Placed for adoption means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption or placement for adoption. Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

No family or household members other than those listed above are eligible to enroll under your coverage.

Special Enrollment Rights

Special Enrollment Periods – Both you and your family members may decline this health coverage during your initial enrollment period. If you are eligible to decline coverage and wish to do so, you must submit a written waiver of coverage to PacificSource through your employer. You and your family members may enroll in this plan later if you qualify under Rule #1, #2, #3, or #4 below.

- **Special Enrollment Rule #1** – If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members may enroll in the plan later if other coverage ends involuntarily. "Involuntarily" means coverage ended because continuation coverage was exhausted, employment terminated, the number of hours of employment 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. You must request enrollment within 31 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.
- **Special Enrollment Rule #2** – If you acquire new dependents because of marriage, domestic partnership, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired dependents at that time. You must request enrollment within 31 days after the marriage, registration of the domestic partnership, birth, or placement for adoption. In the case of marriage and domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.
- **Special Enrollment Rule #3** – If you or your dependents become eligible for a premium assistance subsidy under Medicaid or a State Children's Health Insurance Program, you may be able to enroll yourself and/or your dependents at that time. To do so, you must request enrollment within 60 days of the date you and/or your dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.
- **Special Enrollment Rule #4** – Part-time employees who have declined coverage may enroll if they move to full-time status by submitting an enrollment application within 31 days of the change. Coverage is effective the first of the month following the status change. Full-time employees must enroll during their initial enrollment period.

Late Enrollee – A "late enrollee" is an otherwise eligible employee or dependent who does not qualify for a special enrollment period, and who: did not enroll during the 31-day initial enrollment period; or enrolled during the initial enrollment period but discontinued coverage later. A late enrollee may enroll by submitting an enrollment application to your employer during your open enrollment period. When you or your dependents enroll during the open enrollment period, plan coverage begins on the plan's anniversary date.

Waiving Coverage

You and your family members may decline coverage when you are first eligible. To decline coverage, complete a **Waiver of Coverage form** instead of this form. For more information on your plan's special enrollment provisions, please contact your employer.