2022 Open Enrollment- Terminate coverage for self & dependents on this dental plan

DELTA DENTAL®

Delta Dental of Oregon

Enrollment application & change of information form

Dental (2-4)

Delta Dental use only
Group number _____
Subscriber number _____

To expedite your application, please print legibly in black or blue ink and return as instructed. Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed.

Section 1 › Application type

You'll need a special enrollment reason for some changes made outside the open enrollment period. Special enrollment includes adding dependents to an existing plan and enrolling in the plan due to loss of other coverage. The reason I am applying or making a change is:

Open enrollment

- ☐ New policy/subscriber
- ☐ Add dependent on existing plan
- ☐ Plan change only

Changes

- ☐ Name change
  New name: _____
  Old name: _____
- ☐ New address
  (please write new address in Section 3)

Special enrollment

Date of event: 12 / 31 / 2021

- ☐ Marriage
- ☐ Registered domestic partner (RDP)
- ☐ Birth, adoption or placement for adoption
- ☐ Loss of coverage because I turned 26
- ☐ Loss of coverage due to end of marriage or registered domestic partnership (RDP)
- ☐ Involuntary loss of group coverage
- ☐ COBRA ended due to exhausting benefit
- ☒ Other 2022 Open Enrollment- End All Coverage

Effective Date 1/01/2022

Section 2 › Coverage

☑ Dental coverage

Group name	Group number
City of Springfield	10001700
Subgroup	Class

Section 3 › Employee information

*First name	M.I.	*Last name	*Social Security number	
*Mailing address		*City	*State	*ZIP
			OR	
Home phone	*Date of birth (mm/dd/yyyy)	*Gender	*Date of employment (mm/dd/yyyy)	
	_____ / _____ / _____	☐ M ☐ F	_____ / _____ / _____	
Primary language ☐ English ☐ Spanish ☐ Other _____		Email address		

Section 4 › Dependents

Relationship code: SP = spouse, DP = domestic partner, RDP = registered domestic partner (DP and RDP only if applicable to your plan)

Add	Term	*Dependent first name	*Last	*Social Security number	*Date of birth *(mm/dd/yyyy)*	*Gender	*Relationship	Primary language *(if different from employee)*
☐	☐					☐ M ☐ F	☐ SP ☐ DP ☐ RDP	
☐	☐					☐ M ☐ F	Child[1]	
☐	☐					☐ M ☐ F	Child[1]	
☐	☐					☐ M ☐ F	Child[1]	
☐	☐					☐ M ☐ F	☐ Child[1] ☐ Ward	

** Enrollment will be delayed if fields with an asterisk are not filled out.*
1 Please list only eligible dependent children. See Section 6 for dependent children qualifications.

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Section 5 > Other insurance (coordination of benefits)

Will employee or any dependents have other insurance? ☐ Yes ☐ No

Section 6 > Dependent(s) not living with employee

Are any of the dependent(s) not living with the employee? If yes, please provide the state and ZIP code. This is for informational purposes only and does not impact eligibility.

Dependent name	State	ZIP
Dependent name	State	ZIP
Dependent name	State	ZIP
Dependent name	State	ZIP

Children are eligible to enroll for coverage through age 25. Please see your Member Handbook for additional eligibility information. The following are eligible dependent children:

- Your or your spouse's natural or adoped 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 natural child or adopted child (if domestic partners by affidavit can enroll in your employer plan)
- Your registered domestic partner's natural child or adopted child

Section 7 > Authorization (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.[2] 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. It is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of health coverage.

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 fields with an asterisk are not filled out entirely.

*Employee signature	*Signature date
X	

** Enrollment will be delayed if fields with an asterisk are not filled out.*
2 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 503-952-5033.

Questions? Contact your benefits administrator or visit modahealth.com

601 S.W. Second Ave., Portland, OR 97204-3156

Dental Enrollment Application
and Change of Information Form

Willamette Dental Insurance, Inc.
6950 NE Campus Way, Hillsboro, Oregon 97124

Willamette Dental Group

Please print your answers clearly in ink and fill out both sides of this form so we can process your application quickly. Thank you.

1 I'm filling out this application because I am...

- ☐ a new applicant
- ☐ a retiree
- ☒ a current member: (select a box below)
  - ☐ changing my name
  - ☐ changing my address
  - ☐ changing my dependents
  - ☐ terminating my coverage

  due to...
  - ☒ open enrollment
  - ☐ qualifying event - Type of qualifying event: _____
    Date of qualifying event: 12/31/2021
- ☐ a COBRA member: (select a box below)
  - ☐ 18 months
  - ☐ 29 months
  - ☐ 36 months

  Date of Continuation Qualifying Event: _____

2 My employer information is...

Name of Employer	Group ID	Effective Date	
City of Springfield	OR305	1/1/2022	
Address	City	State	Zip Code
225 Fifth St	Springfield	OR	97477
Work Telephone Number	Occupation	Date of Hire	

3 My information is...

Self (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
Home Address	City/State/Zip	Home Telephone Number
E-mail Address	Date of Birth	Old Name, if applicable

4 I want to enroll my...

Legal Spouse or Domestic Partner (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth ☐ Husband/Wife ☐ Dom. Part.	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete

Please continue application on back...

Dental Enrollment Application Continued...

Willamette
Dental Group

5 Additional dependents...

Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete

6 Other dental insurance I have...

Are you or any of your dependents covered by another dental plan?

☐ Yes ☐ No

If yes, name of enrollee: _____

Name of Carrier: _____ Policy Number: _____

7 Signatures

I hereby apply for coverage through Willamette Dental Insurance, Inc. for myself and for my listed dependents.

I authorize my employer to make payroll deductions from my salary or wages in the amount required, if any, to cover my contribution to coverage with Willamette Dental Insurance, Inc. I authorize any provider of health services to give Willamette Dental Insurance, Inc., upon request, any information concerning the health, condition, or treatment of any person included under such coverage whenever such information is considered necessary for the proper disposition of a claim in fulfillment of obligations imposed on Willamette Dental Insurance, Inc. by State or Federal law.

I certify that all information supplied in this application is true and complete to the best of my knowledge. I agree to advise Willamette Dental Insurance, Inc. of any change in status within 60 days from the date of change. Limited to two years within filing this form, I understand that my coverage may be null and void if I have provided any information which is false or misleading regarding myself or my dependents on this form or any form filed in conjunction with this plan.

Signature of Primary Applicant	Date of Signature