2023 Benefit Open Enrollment

Employee Enrollment and Waiver Form

PacificSource HEALTH PLANS

Group Policy No. Group #G0020720
Subgroup No. ______
Class No. or Plan ______
Are you an owner of this company? ☐ Yes ☒ No

Employer/Group Name CITY OF SPRINGFIELD Effective Date 01 / 01 / 2023 Date of Full-time Hire ___/___/___
Last Name ______ First Name ______ MI ______ Hours Worked per Week ______
Mailing Address ______ City ______ State ______ ZIP ______
Phone ______ Email ______
Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership By providing your email address, you are agreeing to receive email communications from PacificSource.

Enrollment due to:
- ☐ New Group
- ☒ Open Enrollment
- ☐ New Hire
- ☐ Adding Dependent(s)
- ☐ Involuntary Loss of Other Coverage

Effective date:^
01/01/2023

Eligible for COBRA due to:
- ☐ Employment Termination or Reduced Hours
- ☐ Divorce or Legal Separation
- ☐ Death of Employee
- ☐ Dependent No Longer Meets Eligibility

Effective date:^

^Attach proof of event

Choose the type of coverage each person is enrolling in (including those waiving coverage). To add more family members, please attach additional pages.

Coverage		Name (Last, First, MI)	Sex Assigned at Birth	Gender Identity*	SSN	Birth Date	Race/ Ethnicity**
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Employee					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Spouse/Domestic Partner (circle one)					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to Employee:					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to Employee:					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to Employee:					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to Employee:					

***Gender identity** (optional): **A**-Agender, **B**-Boy, **GF**-Gender fluid, **GN**-Gender nonconforming, **GQ**-Genderqueer, **G**-Girl, **M**-Man, **NB**-Non-binary, **NL**-Not listed, **P**-Prefer not to answer, **Q**-Questioning or unsure, **TG**-Third gender, **TM**-Trans man, **TW**-Trans woman, **T**-Transgender, **TS**-Two-spirit, **W**-Woman

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

Do you (or any of the individuals listed above) have a primary care provider? ☐ Yes ☐ No
If yes, please list the name(s) of your primary care provider(s) here: ______

Child Custody: If you, your spouse, or your domestic partner are a Court Ordered Guardian or are required to provide coverage for a child from a previous relationship, then you must complete this section in addition to the previous section, and provide a copy of the legal documentation that shows responsibility for medical expenses. Please use additional paper if needed.

Child's Name _____ Custodial Parent's Name _____

Mailing Address _____ Person Required to Provide Insurance _____

Legal Custody:
Mother Father
Joint Other

Health and Dental Coverage Information: Have you or any person listed on this application had health or dental insurance in the last 60 days? Yes No
If yes, complete the following and attach proof with dates of coverage.

Name	Insurance Carrier	Coverage Dates	Will Coverage Continue?	Coverage Type(s)
	Carrier Name: Policy No.: Phone:	Begin: End:	Yes No	X Medical X Vision Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	Yes No	Medical Vision Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	Yes No	Medical Vision Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	Yes No	Medical Vision Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	Yes No	Medical Vision Dental

Medical Waiver—If employee is declining medical coverage NA

I have qualifying medical coverage through (list carrier name and check coverage type):

Name of Insurance Carrier _____

Through: My other employer My spouse's employer My parent's employer Medicare Medicaid VA/Tricare Indian Health Service

I have other medical coverage through an Individual Policy. I do not have other medical coverage.

Dental Waiver—If employee is declining dental coverage NA

I have qualifying dental coverage through (list carrier name and check coverage type):

Name of Insurance Carrier _____

Through: My other employer My spouse's employer My parent's employer Medicare Medicaid VA/Tricare Indian Health Service

I have other dental coverage through an Individual Policy. I do not have other dental coverage.

Notice of enrollment rights: If you are declining enrollment for you or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends involuntarily, or upon your plan's next open enrollment period, unless otherwise specified in your member handbook.

In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

Subscriber acknowledgment: I acknowledge and understand that PacificSource Health Plans may request or disclose health information about me or my dependents (persons listed for benefit coverage on this enrollment form) for the purpose of facilitating healthcare treatment, payment for healthcare services, or for business operations necessary to administer healthcare benefits; or as required by law. A separate authorization will be used for this information. For more information about such uses and disclosures please refer to our Privacy Policy, available at PacificSource.com.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Employee Signature _____ **Date** _____

You may request a free paper copy of your application and/or enrollment information by contacting us at **866-999-5583** or via email at Membership@PacificSource.com.

Mail: PO Box 7068, Springfield, OR 97475 **Fax:** 541-225-3642

Enrollment application & change of information form

Dual Dental (1 – 99)

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

Moda Health 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

Outside of the open enrollment period, you would need a special enrollment reason to enroll or make changes (for example, add dependents or switch plans). If you are enrolling or making changes due to a special enrollment event, please specify the event below and provide documentation of your life event. The reason I am applying or making a change is:

Open enrollment

Date of event: 12 / 31 / 2022

- ☐ New policy/subscriber
- ☒ Add dependent on existing plan
- ☐ Plan change only
- ☐ *Waiver of coverage (see Section 7)*

Changes *(these can be made outside of open enrollment)*

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

Special enrollment

Date of event: _____ / _____ / _____

- ☐ Marriage
- ☐ Registration of 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/continuation ended due to exhausting benefit
- ☐ Other _____

Section 2 › Coverage

- ☒ Dental coverage
  - ☐ Basic Dental Plan
  - ☐ Basic Dental Plus+(with ortho) Plan

Benefits Effective: 01/01/2023

Group name	Subgroup	Group no.	Class
City of Springfield		10001700	

Section 3 › Employee information

First name*	M.I.	Last name*	Social Security no.*	
Mailing address*		City*	State*	ZIP*
Home phone	Date of birth *(mm/dd/yyyy)**	Gender* ☐ M ☐ F	Date of employment *(mm/dd/yyyy)**	
Primary language ☐ English ☐ Spanish ☐ Other _____		Email address		

Section 4 › Dependent children eligibility information

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 adopted child
- Children placed with you for adoption
- Newborns born to a covered dependent, for whom you are financially responsible (Guardianship is limited to grandchild beyond 31 days from birth if his/her parent is not a covered dependent under the plan. Proof is required.)
- 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's plan)
- Your Registered domestic partner's natural or adopted child

** Enrollment will be delayed if fields with an asterisk are not filled out.*

Section 5 › Dependents

Relationship code: **SP** = spouse, **DP** = domestic partner, **RDP** = registered domestic partner *(DP and RDP only if applicable to your plan)*
Please use additional form if needed.

Add	Term	Dependent first name*	Dependent last name*	Social Security no.*	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] ☐ Ward	

Section 6 › Other insurance (coordination of benefits)

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

If your Group's size is less than 20 employees, Medicare will be assumed to be the primary payer and we will coordinate benefits as the secondary payer even if you have not elected coverage under Medicare. When your Group's size is 20 employees or more, Medicare will be considered the secondary payer.

Section 7 › ~~Waiver of coverage information~~ NA

Please include the names of all eligible members who will NOT be enrolling. *Please use additional form if needed.*

Person waiving	Reason for waiver	Health plan name	Policy no.	Employer group name
	☐ Individual ☐ Employer group ☐ Medicare ☐ Other _____			
	☐ Individual ☐ Employer group ☐ Medicare ☐ Other _____			

Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends.* In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after marriage, birth, adoption or placement for adoption.

** If prior coverage was under Medicaid or a children's health insurance program (CHIP) you must request enrollment within 60 days after the coverage ends.*

Section 8 › Authorization (please read and sign below)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (people 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.*
1 Please list only eligible dependent children. See Section 5 for dependent children qualifications.
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.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Phone (541) 485-7488 ◆ (800) 422-7038
PacificSource.com/PSA

PacificSource ADMINISTRATORS

EMPLOYEE INFORMATION

Employer Name: City of Springfield			
Employee Name:	SSN*:	Date of Birth:	
Mailing Address:	City:	State:	Zip:
Home Phone:	Work Phone:		
Email Address:	Member ID: (if known)		

DEPENDENT INFORMATION

Add the following dependents:

Dependent	Last Name	First Name	Middle Initial	Social Security Number*	Date of Birth
Spouse					
Child					
Child					
Child					
Child					
Child					

* Per Internal Revenue Service (IRS) requirements, Social Security numbers are needed for participants and dependents age 44 and older. For details about this regulation, visit the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov/MandatoryInsRep.

I hereby certify the above information to be correct and true to the best of my knowledge and that the children or dependents for whom I will be claiming dependent expenses either reside with me in a parent-child relationship or are legally dependent on me for their support.

Signature _____ Date _____