Enrollment application & change of information form

Medical (2-99)

ODS use only
Group number ______________________
Subscriber number ______________________

*Group/employer	*Group ID	*Subgroup ID or name	*Class

SECTION 1 | *Coverage*

☒ **Medical coverage**

SECTION 2 | *Type of application*

☐ **New enrollment or rehire**, Effective date: _____ /_____ /_______
☐ **Open enrollment**
☐ **Term dependent,** Effective date: _____ /_____ /_______
Reason: ______________________
(*List dependent(s) to term in dependent section)*
☐ **COBRA/Continuation**, Effective date: _____ /_____ /_______
Reason: ______________________

SECTION 3 | *Changes*

☐ **Address change**
(please write new address in the Employee information section of this form)
☐ **Name change** Old name: ______________________
New name: ______________________

SECTION 4 | *Add dependent(s)*

Please select a qualifying event from the list below if the dependent addition is not due to open enrollment, new hire or rehire.

☐ **Newborn birth**
☐ **Adoption placement**
(adoption paperwork required with enrollment)
☐ **Court appointed guardian** *(court order of legal guardianship is required with enrollment)*
☐ **Loss of group coverage**
(Certificate of Creditable Coverage required)
☐ **Marriage** *(marriage certificate required with enrollment)*
☐ **Domestic partner affidavit**
(domestic partner affidavit required with enrollment)
☐ **Oregon Registered Domestic Partner** *(Registered Domestic Partnership Certificate required with enrollment)*

Date of qualifying event: _____ /_____ /_______

SECTION 5 | Employee information *Please complete this form and sign on the back. Please type or print legibly in ink. Thank you!*

*Employee first name	M.I.	*Employee last name	*Employee Social Security number

*Employee mailing address	*City	*State	*ZIP

Home phone	*Date of birth (mm/dd/yyyy)	*Gender	*Date of employment (mm/dd/yyyy)
		☐ M ☐ F	

Primary language:	Email address
☐ English ☐ Spanish ☐ Other ______________	

SECTION 6 | *Dependents* ***List only eligible dependent children. See reverse side of form for dependent children qualifications.*

*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	M.I.	*Last	*Date of birth (mm/dd/yyyy)	*Gender	*Relationship	Primary language (if different from employee)
☐	☐					☐ M ☐ F	☐ Spouse ☐ DP ☐ RDP	
☐	☐					☐ M ☐ F	Child**	
☐	☐					☐ M ☐ F	Child**	
☐	☐					☐ M ☐ F	Child**	
☐	☐					☐ M ☐ F	☐ Child** ☐ Ward	

*Spouse/DP/RDP Social Security number	Spouse/DP/RDP email address

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

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SECTION 7 | *Other insurance* *Coordination of benefits*

Will employee or any dependents have **other** insurance? ☐ Yes ☐ No
If yes, complete a Coordination of Benefits Form.

SECTION 8 | *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.

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

**A child is eligible for coverage if he/she meets the dependent eligibility requirements of the employee's plan. See your Member Handbook for details. The following are eligible dependent children:

- Your natural child
- Your step-child or adopted 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 applicable to your employer plan)*
- Your Registered domestic partner's natural child or adopted child *(if applicable to your employer plan)*

SECTION 9 | *Pre-existing Condition Exclusion* *For members enrolling in medical plan*

Were you or any of your dependents age 19 or older covered through another group or individual plan at any time during the past 63 days before your effective date of coverage under this plan, or the first day of any required group eligibility waiting period under this plan?

☐ No ☐ Yes. If yes, please attach your Certificate of Creditable Coverage from your current or prior health plan. A pre-existing period may be reduced by any prior creditable health coverage.

SECTION 10 | *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.* 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 fields with an asterisk are not filled out entirely.

*Employee signature X	*Signature date

If you have questions, please contact your benefits administrator.

Insurance products in Oregon provided by ODS Health Plan, Inc. Health plans in Washington provided by ODS Health Plan, Inc.