City of Albany
Enrollment Application and Change Form

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

Enrollment Information

Group Policy No.	Medical Classes (select one)			
PacificSource G0020038 Moda Health Willamette Dental	☐1001 AFSCME ☐1002 APA ☐1003 NB ☐1501 Temp	☐1201 DC AFSCME ☐1202 DC APA ☐1203 DC NB	☐7002 DC APA Retiree ☐7003 DC AFSCME & NB Retiree ☐7101 APA Retiree ☐7103 Retiree Pre-Tax Sub ☐7104 AFSCME & NB Retiree	☐9001 DC APA COBRA ☐9003 DC AFSCME & NB COBRA ☐9101 APA COBRA ☐9103 AFSCME & NB COBRA

Type of New Enrollment
☐New Employee or Rehire ☐Open Enrollment ☐COBRA Qualifying Event ☐Employee Classification Change
☐Name Change ☐Address, Phone, or E-mail Change ☐Adding Members ☐Terminating Members

Section 1A – Continuation of Coverage (COBRA)
Date of qualifying event:________________
Event: ☐Termination of employment or reduction in hours
☐Divorce or legal separation
☐Dependent no longer meets eligibility
☐Death of a covered employee

Section 1B – Name Change
Old Name:________________
New Name:________________
Effective Date of Change:________________

Section 1C – Adding Spouse, Partner, or Child (attach proof)
Date of qualifying event:________________
Event: ☐New Hire ☐Marriage ☐Open Enrollment
☐Birth ☐Adoption ☐Court Order
☐Involuntary loss of other group coverage
☐Domestic Registration ☐Domestic Affidavit

Section 1D – Terming Spouse, Partner, or Child
Date of termination:________________
Name(s):________________
____
Reason:________________

Employee Information

Date of Full Time Hire (required)	Number of Hours Worked Per Week	Effective Date
month________ day______ year______		month________ day______ year______

Employee Last Name	First Name	M.I.

Mailing Address	City	State	Zip code

Home Phone No.	E-Mail Address	Job Title

Gender	Marital Status
☐Male ☐Female	☐Married ☐Single ☐Domestic Partner–If domestic partner, are you registered with the State of Oregon? ☐Yes ☐No

Employee and Family Members You Wish to Enroll

[1] Ethnicity/Race Code: **AIAN**-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[1]***	*Coverage*
Employee					☐Medical ☐Moda Dental ☐WDS Dental
Spouse or Domestic Partner					☐Medical ☐Moda Dental ☐WDS Dental
Dependent Child					☐Medical ☐Moda Dental ☐WDS Dental
Dependent Child					☐Medical ☐Moda Dental ☐WDS Dental
Dependent Child					☐Medical ☐Moda Dental ☐WDS Dental
Dependent Child					☐Medical ☐Moda Dental ☐WDS Dental

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:	☐Yes ☐No	☐Dental–Does plan cover pediatric dental? _Yes _No ☐Medical ☐Vision
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐Yes ☐No	☐Dental–Does plan cover pediatric dental? _Yes _No ☐Medical ☐Vision

Married or Domestic Partner – Is your spouse or 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
			☐Age ☐ERSD ☐Disability ☐Dual Entitlement

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 group health insurance carriers 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
	☐Yours ☐Spouse	☐Yes ☐No				
	☐Yours ☐Spouse	☐Yes ☐No				

Electronic Communications

By checking the following box, you affirmatively consent to the following: (1) to submit your application for enrollment on a PacificSource Health Plans ("PacificSource") group policy filed electronically over a secured internet connection, (2) your electronic submission has the same force and effect as if you had submitted a paper application to PacificSource with your signature, (3) to receive secured electronic communications from PacificSource regarding your application and/or enrollment status, and (4) to keep PacificSource informed of your current e-mail address that it may use to correspond with you.

You may, at any time, opt out of these electronic communications or request a free paper copy of your application and/or enrollment information by contacting our Membership Department at membership@pacificsource.com, or toll-free at 866.999.5583. Electronic communications are offered as a convenience only and your decision not to receive electronic communications will not affect your enrollment and there is no charge associated with switching to paper. PacificSource highly recommends you keep a copy of your application and any associated materials.

In order to complete the application electronically, you must have a personal computer or other device capable of accessing the internet and the ability to view and revise Portable Document Format (PDF) files. You can obtain a free copy at http://get.adobe.com/reader/. PacificSource takes the security of electronic information and communications seriously. If you have any questions about our encryption, technical hardware or software, or our security policies and procedures, please contact us at membership@pacificsource.com.

I agree: ☐Yes ☐No Email Address:____

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 healthcare treatment, payment, or for business operations necessary to administer healthcare 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**