



OPEN ENROLLMENT for 2012 Plan Year.

# Enrollment Application and Change of Information Form

## Dental Only 100+

**ODS use only**

Group Number \_\_\_\_\_

Subscriber Number \_\_\_\_\_

\*Group/Employer City of Springfield \*Group ID: \_\_\_\_\_ \*Subgroup ID or Name: \_\_\_\_\_ \*Class: \_\_\_\_\_

<p><b>* Coverage:</b></p> <p><input checked="" type="checkbox"/> <b>Dental Coverage</b></p> <p>Effective: <u>1/1/2012</u></p>	<p><b>Type of Application</b></p> <p><input type="checkbox"/> <b>New Enrollment or Rehire</b> Effective Date: _____</p> <p><input checked="" type="checkbox"/> <b>Open Enrollment</b></p> <p><input type="checkbox"/> <b>Term Dependent</b> Effective Date: _____ Reason: _____</p> <p>List Dependent(s) to Term in Dependent section.</p> <p><input type="checkbox"/> <b>COBRA</b> Effective Date: _____ Reason: _____</p>	<p><b>Changes</b></p> <p><input type="checkbox"/> <b>Address Change</b> <input type="checkbox"/> <b>Name Change</b> Old Name: _____ New Name: _____</p> <p><input type="checkbox"/> <b>Add Dependent(s)</b> - List Dependent(s) to add in Dependent section. Dependent adds require a qualifying event date unless added during open enrollment.</p> <table border="0"> <tr> <td>Newborn Birth Date: _____</td> <td>Court Appointed Guardian Date: _____</td> <td>Oregon Registered Domestic Partner Date: _____</td> </tr> <tr> <td>Adoption Placement Date: _____</td> <td><b>(Court Order of Legal Guardianship is required with enrollment)</b></td> <td><b>(Registered Domestic Partnership Certificate required with enrollment)</b></td> </tr> <tr> <td>Marriage Date: _____</td> <td>Loss of Group Coverage Date: _____</td> <td></td> </tr> <tr> <td><b>(Adoption paperwork required with enrollment)</b></td> <td></td> <td></td> </tr> <tr> <td><b>(Marriage certificate required with enrollment)</b></td> <td></td> <td></td> </tr> <tr> <td>Domestic Partnership Affidavit Date: _____</td> <td></td> <td></td> </tr> <tr> <td><b>(Domestic Partner Affidavit required with enrollment)</b></td> <td></td> <td></td> </tr> </table>	Newborn Birth Date: _____	Court Appointed Guardian Date: _____	Oregon Registered Domestic Partner Date: _____	Adoption Placement Date: _____	<b>(Court Order of Legal Guardianship is required with enrollment)</b>	<b>(Registered Domestic Partnership Certificate required with enrollment)</b>	Marriage Date: _____	Loss of Group Coverage Date: _____		<b>(Adoption paperwork required with enrollment)</b>			<b>(Marriage certificate required with enrollment)</b>			Domestic Partnership Affidavit Date: _____			<b>(Domestic Partner Affidavit required with enrollment)</b>		
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**Please complete this form and sign on the back. Please type or print legibly in ink. Thank you!**

* Employee First Name	M.I.	* Last	* Birth Date mm/dd/yy	* Gender <input type="checkbox"/> M <input type="checkbox"/> F	* Date of Employment mm/dd/yy
* Employee Mailing Address	* City	* State	* Zip	* Employee Social Security #	Home Phone Number
Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			E-mail Address		

**Relationship code: SP = Spouse, DP = Domestic Partner, RDP = Registered Domestic Partner (DP and RDP only if applicable to your plan)**

Add	Term	* Name (Only list those you wish to add/delete) * First M.I. * Last	* Birth date	* Gender	* Relationship	* Social Security Number	Primary Language (If different from employee)	E-mail Address
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> RDP			
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F	Child	N/A		N/A
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F	Child	N/A		N/A
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F	Child	N/A		N/A
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Ward	N/A		N/A

**Other Insurance (Coordination of Benefits)**

Will employee or any dependents have other insurance?  Dental  No Other Dental Insurance

# ODS Enrollment Application

**It is VERY important that the employee sign and date below. Thank you!**

Are any of the dependent(s) a full-time college student and/or not living with the employee? If yes, please provide the state, zip code and school name if applicable.

Dependent name: \_\_\_\_\_  
School Name \_\_\_\_\_

Dependent name: \_\_\_\_\_  
School Name \_\_\_\_\_

Dependent name: \_\_\_\_\_  
School Name \_\_\_\_\_

Dependent name: \_\_\_\_\_  
School Name \_\_\_\_\_

## Covered Dependent Children Definition

An unmarried 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)

### 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.

*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 the red fields are not filled out entirely.*

**\* X**

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.

**\* Date:**

**REQUIRED**

\_\_\_\_\_

\_\_\_\_\_