Employee Enrollment Form

Oregon State University – GSE

PacificSource HEALTH PLANS

FOR EMPLOYER

Group no. **G0021007**

Group name **Oregon State University - GSE**

Subgroup no. ☒ P001-Active ☐ P002-COBRA

Class no. or plan name ☐ 1001 - Graduate assistant ☐ 1002 - Graduate fellow ☐ 1003 - Postdoctoral scholars ☐ 1006 - Clinical fellows ☐ 9001 - COBRA

Date of hire: _____/_____/_____ Coverage effective date: _____/_____/_____

Hours worked per week: _____ Is applicant an owner? ☐ Yes ☒ No

Last name _____ First name _____ MI _____

Mailing address _____

City _____ State _____ Zip _____

Phone _____ Email _____

UniversityID _____

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:^

_____

Eligible for COBRA due to:

☐ Employment termination or reduced hours
☐ Divorce or legal separation
☐ Death of employee
☐ Dependent no longer meets eligibility

Effective date:^

_____

^Documentation may be required.

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	Employee	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Name: Primary care physician:					
☐ Medical	☐ Add ☐ Waive	Spouse/domestic partner	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Name: Primary care physician:					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to employee: Primary care physician:					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to employee: Primary care physician:					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to employee: Primary care physician:					

***Gender identity** (optional): **A**-Agender, **F**-Female/Woman, **GF**-Gender fluid, **GN-**Gender nonconforming, **GQ**-Genderqueer, **M**-Male/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

****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.

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	☐ 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
	Carrier name: Policy no.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental

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