GROUP HEALTH PLAN ENROLLMENT

PacificSource ADMINISTRATORS

PacificSource Administrators
Box 70088 • Eugene, OR 97401
(888) 532-5332
tpa.pacificsource.com

☐ Enrollment ☐ Change ☐ Termination

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

Section 1 – Employee Information

Employee Last Name	First Name	M.I.	Social Security Number *Write number in boxes across*
Address			_ _ _ - _ _ - _ _ _ _
City	State	Zip code	Home Phone ( ) -
Mailing Address / City	State	Zip Code	Mobile Phone ( ) -
Gender ☐ M ☐ F	Birth Date (mm/dd/yyyy)	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated	E-Mail

☐ New Employee	☐ Open Enrollment	☐ Termination
☐ Add Dependent(s)	☐ Rehire	☐ Change Name/Address
☐ Drop Dependent(s)	☐ Reinstatement	☐ Decline Coverage

Section 2 – Family Information

Complete for yourself and each family member you wish to enroll.

Name (Last Name, First Name M.I.)	Gender	Birth Date (mm/dd/yyyy)	Social Security Number
Employee	See Above		See Above
Spouse	☐ Male ☐ Female		
Child	☐ Male ☐ Female		
Child	☐ Male ☐ Female		
Child	☐ Male ☐ Female		
Child	☐ Male ☐ Female		
Child	☐ Male ☐ Female		
Child	☐ Male ☐ Female		

Plan Selection (choose one):	**Plan Name/Number:**
☐ Medical and Dental ☐ Medical Only ☐ Dental Only	

Section 3 – Employer Information – Personnel Use Only

Employer/Group Name:			Location #
Employee Date of Full Time Hire/Rehire	Eligibility Date	Enrollment/Effective Date	Termination Date
Plan #	Network:	Admin #	

Section 4 – Other Coverage

Do you or any enrolling family members have or have had any prior medical coverage?
☐ No ☐ Yes – If yes, please attach proof of prior coverage (certificate of coverage or other proof with dates of coverage)

Existing Coverage - After enrolling in your employer's benefits plan(s), will you or any of your dependents have any other additional health insurance?
☐ No ☐ Yes – If yes, please complete the following:

Names of Everyone with ***Other Current*** Coverage	Insurance Carrier Name	Insurance Carrier Phone No	Policy or ID Number	Type of Coverage
				☐ Medical ☐ Dental ☐ Vision ☐ Retiree
				☐ Medical ☐ Dental ☐ Vision ☐ Retiree
				☐ Medical ☐ Dental ☐ Vision ☐ Retiree

Medicare – If you or any person enrolling has Medicare, is coverage: ☐ Part A ☐ Part B ☐ Part D

Name of Insured	Original Effective Date	Reason for Medicare Entitlement	Medicare No. (include alpha prefix)
		☐ Age ☐ Disability ☐ ERSD ☐ Dual	
		☐ Age ☐ Disability ☐ ERSD ☐ Dual	

Section 5 – Child Custody Information

If you are enrolling children of a previous marriage, you must complete this section indicating the custodial parent. The Plan must provide information to the custodial parent. Also list any children for whom you have court-ordered coverage.

Child's Name	Whose Child	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone No.	If Court Order, Name of Person Responsible for Insurance
	☐ Yours ☐ Spouse				
	☐ Yours ☐ Spouse				
	☐ Yours ☐ Spouse				

Section 6 – Health Information 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 health care treatment, payment, or for 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 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 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 hereby apply for benefits under my employer's group benefit plan(s). I authorize payroll deductions, if required, for the cost of the coverage I have selected. I certify that the information given on this enrollment form is complete and correct, and I understand that if the information is not complete and correct, this coverage could be retroactively terminated.

Employee Signature ______________ **Date** ______________ **Phone No.** ______________