

DOUGLAS COUNTY HEALTH AND DENTAL ENROLLMENT APPLICATION

Detach and
keep for your
records.

Instructions

This enrollment application contains two parts: the Disclosures Section and the Enrollment Information Section.

- **Read the Disclosures Section carefully.** This information will help you understand certain requirements of your employer's plan.
- **Detach the Disclosures page** and save it for future reference.
- **Complete the Enrollment Information Section.** Be sure to answer everything in this application that applies to you. It is important that you provide all requested information so your benefits can be administered correctly. Please be sure to sign and date the form. If a spouse is enrolling, be sure they sign and date the form, also.
- **Return the Enrollment Information page to your plan administrator.**

Disclosures Section

Pre-Existing Condition and Other Exclusion Periods – Guidelines for Section 4

What is a pre-existing condition? A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended by or received from a licensed provider during a six-month "look back" period. That look back period is the six-month period ending on your enrollment date or the first day of your employer's probationary waiting period, whichever is earlier. For late enrollees, the look back period ends on the effective date of coverage.

How long is coverage for pre-existing conditions excluded? The plan excludes pre-existing conditions for six months. The six-month period begins on your enrollment date. However, if your employer's waiting/probationary period is longer than four months and you do not have creditable prior coverage, your exclusion period will be reduced so that pre-existing conditions are covered 10 months after your waiting/probationary period began.

What other conditions have exclusion periods and how long are they? The plan excludes coverage for organ transplants and any related services for 24 months. If you are enrolling in a Preferred plan, your plan also excludes coverage for elective procedures, surgery for ear infections, removal of tonsils or adenoids, and sterilization for six months. (Prime and Choice plans do not have this exclusion.)

If I had prior health coverage, will my exclusion periods be shortened or eliminated? You can receive credit toward this plan's exclusion periods if you had qualifying healthcare coverage before enrolling in this plan. To qualify for this credit, there may not have been more than a 63-day gap between your last day of coverage under the previous health plan and your first day of coverage (or the first day of your employer's eligibility waiting/probationary period) under this plan. Also, your prior coverage must have been a group health plan, COBRA or state continuation, individual health insurance policy (including student health plans), Medicaid, Medicare, CHAMPUS, State Children's Health Insurance Program, and coverage through high risk pools and the Peace Corps. If you were covered as a dependent under a plan that meets these qualifications, you will qualify for credit. Many people elect the COBRA or state continuation coverage available under a prior plan to make sure they won't have more than a 63-day gap in coverage.

It is your responsibility to show us you had creditable coverage in writing. If you qualify for credit, we will count every day of coverage under your prior plan toward this plan's exclusion periods for pre-existing conditions, other specified conditions, and transplants.

How can I prove my prior creditable coverage? You can show evidence of creditable coverage by sending us a Certificate of Creditable Coverage from your previous health plan. All health plans, insurance companies, and HMOs are required by law to provide these certificates on request, and most issue these certificates automatically whenever someone's coverage ends. The certificate shows how long you were covered under your previous plan and when your coverage ended.

If you do not have a certificate of prior coverage, contact your previous insurance company or plan sponsor (such as your former employer, if you had a group health plan). You have the right to request a certificate from any prior plan, insurer, HMO, or other entity through which you had creditable coverage. If you are unable to obtain a certificate, please contact the PacificSource Membership Services Department and we will assist you.

Example of how your plan's exclusion period rules work. Mike worked at Oldco, and was covered under Oldco's group health plan for five months. He did not have any health coverage before his Oldco group plan.

Mike quit his job at Oldco and did not elect the COBRA continuation coverage. Exactly 60 days after quitting his job at Oldco, Mike was hired for a full time, benefits eligible job at Newco. Newco has a PacificSource group health plan with the same exclusion periods and rules as your employer's plan. Mike enrolled in Newco's group plan as soon as he satisfied Newco's eligibility waiting/probationary period.

- Mike will receive credit for the Oldco coverage because the gap between his last day under the Oldco plan and his hire date at Newco was less than 63 days.
- Mike will receive five months of prior coverage credit for the Oldco plan, so his pre-existing conditions exclusion period is reduced to one month. That one-month period begins on his enrollment date (after he satisfies Newco's eligibility waiting/probationary period).
- Mike's pre-existing conditions look back period is the six months ending on his hire date.
- The other specified conditions (elective procedures, surgery for ear infections, removal of tonsils or adenoids, and sterilization) are also excluded for one month, and transplants are excluded for 19 months (24 months reduced by five months of prior coverage credit).

Special Enrollment Rights

The group plan offered by your employer contains provisions that, in certain situations, may allow your family members to enroll in the plan later if they decline enrollment when they are first eligible. These special enrollment rights affect your eligible family members. If your family members decline coverage when they are eligible, they may enroll in the plan later if they qualify under Rule #1, #2, or #3 below.

Special Enrollment Rule #1

If you decline enrollment for your dependents, your eligible family members may enroll in this plan during the annual open enrollment period.

Annual Open Enrollment Period: November 1 – December 15

Effective Date of Enrollment Change: January 1

Special Enrollment Rule #2

If you decline enrollment for your dependents because of other group insurance coverage, your family members may be able to enroll in the plan later if the other coverage ends involuntarily. "Involuntarily" means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, the other insurance plan was discontinued or the maximum lifetime benefit of the other plan was exhausted, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation. To do so, you must request enrollment within 31 days after their other group insurance coverage ends.

Special Enrollment Rule #3

If you acquire new dependents because of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new dependents at that time. To do so, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

For more information on your plan's special enrollment provisions, please refer to your Member Benefit Handbook(s).

Primary Care Physician (PCP)

When enrolling in the Prime plan, you and your family members must each select a PCP from the Prime plan's provider directory. Your family members may each choose a different PCP, or share the same one. Your PCP is extremely important since the PCP will be the first person you call when you need medical care to receive the highest level of benefit for most covered services. The PCP assumes primary responsibility for medical care, requests referral for more specialized services when needed, and maintains your medical records.

Contact Information

**PacificSource Health Plans
Medical Benefits
Customer Service Department**
541-684-5582 or 888-977-9299
E-mail cs@pacificsource.com
Website www.pacificsource.com

**Oregon Dental Services
Dental Benefits
Customer Service Department**
503-265-5680 or 877-277-7280
E-mail link from website
Website www.odshealthplans.com

**Willamette Dental Group
Dental Benefits
Appointments**
800-461-8994 Oregon
503-644-3200 Portland Metro
800-359-6019 Washington

DOUGLAS COUNTY HEALTH AND DENTAL ENROLLMENT APPLICATION

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

Section 1 – Purpose of This Form

Select Reason

- | | |
|--|---|
| <input type="checkbox"/> Enrolling employee only at initial eligibility
<input type="checkbox"/> Change at open enrollment
<input type="checkbox"/> Name change – Previous name: _____
<input type="checkbox"/> Adding dependents – Reason: <input type="checkbox"/> Open enrollment <input type="checkbox"/> Marriage (date) _____ <input type="checkbox"/> Birth (date) _____ <input type="checkbox"/> Other _____
<input type="checkbox"/> Deleting dependents – Reason: <input type="checkbox"/> Open enrollment <input type="checkbox"/> Divorce (date) _____ <input type="checkbox"/> Overage child <input type="checkbox"/> Other _____ | <input type="checkbox"/> Enrolling employee & dependents at initial eligibility
<input type="checkbox"/> Change of address and/or phone number
<input type="checkbox"/> Primary Care Physician (PCP) Change |
|--|---|

Section 2 – Employee Information

Employee Plan Selection – Select one medical plan and one dental plan

- Select one medical plan: Prime High Medical–Group C063 Preferred CDHP HRA–Group C064
 Select one dental plan: ODS High Dental–Group 6944 ODS Low Dental–Group 6945 Willamette Dental Plan

Employee Date of Hire	Number of Hours Worked Per Week	Enrollment Date
Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA	Job Title	Social Security Number <i>Write number in boxes across, then darken circles for number below.</i>
Employee Last Name	First Name	M.I.
Mailing Address	City	State
Home Phone No.	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (requires affidavit)		

Section 3 – Family Information

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

FOR PRIME MEDICAL PLAN ONLY*

Name	Gender	Birth Date	Name of Primary Care Practitioner required to enroll in the Prime Plan. Refer to Prime Provider Directory.	Established Patient?
Employee				<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No

If any family members listed above have last names which are different from yours, explain their relationship to you:

If any child listed above is over 18 and a full-time student, please list the school he/she attends and location.

Section 4 – Other Coverage

You may provide evidence of prior coverage to reduce your medical pre-existing condition exclusion period. (Refer to Disclosures Section)

Did you or any enrolling family members have any medical coverage?

No Yes – If yes, please attach proof of prior coverage (copy of ID card, certificate of coverage, or other proof)

Existing Coverage – Coordination of Benefits

After enrolling with PacificSource, ODS, and/or Willamette, will you or any dependents have any other additional health insurance? No Yes – complete the following:

Names of Everyone with Other Current Coverage	Insurance Company Name and Phone No.	Policy or ID Number	Type of Coverage
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree

If married: Is your spouse employed? No Yes Self employed

Medicare Information

Name of Insured	Type of Coverage	Original Effective Date
	<input type="checkbox"/> Part A <input type="checkbox"/> Part B	

Section 5 – Child Custody Information

If you are enrolling children of a previous marriage, you must complete this section. List court ordered coverage in Section 4 above. Oregon law requires PacificSource, ODS, and Willamette Dental to provide plan information to the custodial parent.

Child's Name	Whose Child?	Who has Custody?	Name/Address/Phone No. of Custodial Parent if not Self	If Court Order, Name of Person Responsible for Insurance
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse's	<input type="checkbox"/> You <input type="checkbox"/> Joint <input type="checkbox"/> Other		
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse's	<input type="checkbox"/> You <input type="checkbox"/> Joint <input type="checkbox"/> Other		
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse's	<input type="checkbox"/> You <input type="checkbox"/> Joint <input type="checkbox"/> Other		

Section 6 – Health Information Acknowledgment 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 acknowledgment 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.

Employee Signature

Date