PacificSource Health Plans
Medical Customer Service
7:00 am – 5:00 pm Mon-Fri
541.684.5582 or 888.977.9299
PacificSource.com

City of Albany
Enrollment Application and Change Form

Moda Health
Dental/Vision Customer Service
7:30 am – 5:30 pm Mon-Fri
503.265.2965 or 888.217.2365
modahealth.com

This enrollment application contains two parts: the enrollment form (pages 1–2) and information (page 3-4).

- **Please read the information pages carefully** to help you understand requirements of your employer's health plan.
- **Complete, sign, and date the enrollment form.** Be sure to answer everything that applies to you.
- **Detach this information page and make a copy of the form.** Keep these pages with your own insurance records.
- **Return the original, completed form to your employer**.

Employee and Family Members You Wish to Enroll

Dependents – Dependents of a covered employee who meet one of the following requirements may also be eligible for enrollment if this plan covers. Please contact your employer to determine if dependents are eligible to enroll under this plan.

- Your legal spouse or qualified domestic partner.
- Your, your spouse's, or your qualified domestic partner's dependent children or foster child under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your spouse's, or your qualified domestic partner's unmarried dependent children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage.
- Your sibling, niece, nephew, or grandchild under age 19 who is unmarried, or not in a qualified domestic partnership, who is related to you by blood, marriage, or qualified domestic partnership AND for whom you are the court appointed legal custodian or guardian with the expectation that the family member will live in your household for at least a year.
- A child placed for adoption with you, your spouse, or qualified domestic partner. Placed for adoption means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption or placement for adoption. Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

No family or household members other than those listed above are eligible to enroll under your coverage.

Special Enrollment Rights

Special Enrollment Periods – To find out if your employer's plan allows employees to decline coverage, ask your health plan administrator. If allowed, both you and your family members may decline coverage during your initial enrollment period. If you wish to do so, you must submit a written waiver of coverage to PacificSource through your employer. You may enroll in this plan later if you qualify under Rule #1, Rule #2, or Rule #3 below. If your employer's plan allows dependent, they may enroll at the same time as you.

If you enroll during your initial enrollment period and your family members are eligible for coverage, they may decline coverage and enroll in the plan later if they qualify under Rule #1, Rule #2, or Rule #3 below.

- *Special Enrollment Rule #1* – If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members may enroll in the plan later if the other coverage ends involuntarily. You must request enrollment within 60 days after the other coverage ends (or within 60 days after the other coverage ends if it is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.
- *Special Enrollment Rule #2* – If you acquire new dependents because of marriage, newly qualified domestic partnership, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired dependents at that time. You must request enrollment within 31-days after the qualifying event. In the case of marriage or domestic partnership, coverage begins on the first day of the month after the event. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.
- *Special Enrollment Rule #3* – If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and/or your dependents at that time. You must request enrollment within 60 days of the date of eligibility for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollee – *If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the plan's next designated open enrollment period.* A 'late enrollee' is an otherwise eligible employee or dependent who does not qualify for a special enrollment period explained above, and who: did not enroll during the initial enrollment period; or enrolled during the initial enrollment period but discontinued coverage later.

Continuation of Coverage Rights Under COBRA

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Note: If you are the spouse of an employee, and you are 55 years of age or older, and your spouse dies or you divorce or legally separate from your spouse, COBRA continuation may be extended beyond the normal 36 month period for that qualifying event.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

Enrollment Information

Group Policy No.
PacificSource G0020038
Moda Health
Willamette Dental

Medical Classes (select one)
☐1001 AFSCME ☐1201 DC AFSCME ☐7101 Retiree ☐9101 COBRA
☐1002 APA ☐1202 DC APA ☐7002 DC Retiree ☐9001 DC COBRA
☐1003 NB ☐1203 DC NB ☐7103 Retiree Pre-Tax Subsidized
☐1501 Temp

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 ☐Male ☐Female

Marital Status ☐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**