



# Pacific Health Trust Enrollment / Change / Waiver Form

GROUP NAME: \_\_\_\_\_ GROUP ID: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MEDICAL PLAN: \_\_\_\_\_ DENTAL PLAN:  1000  1500  2000 VISION PLAN: \_\_\_\_\_

New Enrollment  Enrollment Change  Address Change  Name Change Reason: \_\_\_\_\_

**Enrollment Reasons:** New Employee, Rehired Employee, Open Enrollment, Transfer From Other Plan Offered by Group, Employee Entered Eligible Class (Part-time to Full-time, Temporary to Permanent, Job Title Change), Marriage, Divorce, Death, Birth, Adoption (Legal Documents May Be Required), Dependent Change, and Involuntary Loss of Other Coverage (Prior Coverage Certificate required)

**1. GROUP INFORMATION (TO BE COMPLETED BY THE GROUP):** Date of Hire \_\_\_\_/\_\_\_\_/\_\_\_\_ or Employee entered eligible class on \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Job Title: \_\_\_\_\_ Hours Per Week: \_\_\_\_\_ Work Location: \_\_\_\_\_ Class \_\_\_\_\_

**2. EMPLOYEE INFORMATION (EMPLOYEE TO COMPLETE SECTIONS 2-10)** Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Social Security Number: \_\_\_\_\_ -- \_\_\_\_ -- \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Mailing Address (If Different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Business Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

**3. DEPENDENT ENROLLMENT INFORMATION** Notes: Please check the Enroll or Delete box for each enrollee. Use a separate sheet to list additional enrollees. **If Waiving Coverage go to Section 8.**

Medical		Dental		Relationship to Employee	Name (Last, First, MI)	Social Security Number**	Gender M/F	BirthDate (MO/Day/YR)	Date of Event***
Enroll	Delete	Enroll	Delete						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spouse/State Reg DP* <input type="checkbox"/> Domestic Partner					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

\* Domestic Partner \*\* Federal regulation requires this information for enrollment \*\*\*Date of Marriage, Divorce, Adoption, Death, or Loss of Coverage

Is any child over the dependent age limit of 26 applying for coverage eligible due to disability?  No  Yes, complete and attach the Request for Certification of Disabled Dependent.

**4. MEDICARE FOR EMPLOYEE AND ALL DEPENDENTS**

Is any person applying covered by Medicare?  No, go to section 5  Yes, please complete the following:

Name \_\_\_\_\_ Medicare ID # \_\_\_\_\_ Effective Date: Part A \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason:  Age  Disability

End Stage Renal Disease

Name \_\_\_\_\_ Medicare ID # \_\_\_\_\_ Effective Date: Part A \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason:  Age  Disability

End Stage Renal Disease

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(continued)

## 5. CONTINUED COVERAGE FOR SPOUSE AND DEPENDENTS

Is your spouse/State Registered DP or child applying for continued coverage?  No  Yes, complete and attach a COBRA Enrollment Form.

## 6. PRIOR COVERAGE FOR ENROLLING EMPLOYEE AND ALL DEPENDENTS

Have you and/or eligible dependents been covered by other medical insurance in the past six (6) months?

No, go to section 7  Yes, please complete the following section: **Notes:** Some Groups have a waiting period before an employee is eligible for benefits. If you are not sure of your enrollment date, please contact your Group Benefits Administrator. Use a separate sheet to list additional prior carrier coverage.

Prior Plan Name \_\_\_\_\_ Prior Plan Phone Number ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Date Coverage Began \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Subscriber ID Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Names of all Person(s) Covered \_\_\_\_\_

Will this coverage be in effect after the coverage with this plan begins?  Yes  No, enter date coverage ended \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## 7. OTHER COVERAGE FOR ENROLLING EMPLOYEE AND ALL DEPENDENTS *Helpful Hint: Failure to complete prior coverage information could affect payment of claims.*

Will any person applying for coverage be covered under another plan after the coverage with this plan begins?  No, go to section 8  Yes, complete the following section:

Other Plan Name \_\_\_\_\_ Other Plan Phone Number ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Date Coverage Began \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Subscriber ID Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Names of all Person(s) Covered \_\_\_\_\_

Is this person covered as a retired or laid-off employee or is this person a covered dependent of such an employee?  No, go to section 8  Yes, enter the date retired or laid-off \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**8. DECLINING COVERAGE:** This is to confirm that I decline to participate in the Health Insurance and / or Dental Insurance program offered through my employer's group plan as follows:

### Medical:

I do not wish to enroll myself. I have other medical coverage. **(Please Note: If your company offers Vision coverage, Vision enrollment must match Medical enrollment.)**

I do not wish to enroll myself. I do not have other medical coverage.

Dental:  I Decline Dental Coverage for myself (Also waives ALL dependent coverage)

I do not wish to enroll my  spouse/state registered DP  children.\* They have other medical coverage.

I do not wish to enroll my  spouse spouse spouse/state registered DP in Dental

I do not wish to enroll my  spouse spouse/state registered DP  children.\* They do **not** have other medical coverage  I do not wish to enroll my children in Dental.

\*Please list the names of specific children you wish to waive if you are not enrolling all of them: \_\_\_\_\_

If you are declining health coverage enrollment for yourself or dependents (including your spouse/State Registered DP) because of other coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have **involuntarily** lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within the time period allowed (see your Certificate). If you request coverage for yourself and/or eligible dependents at a later date, coverage may be subject to late enrollment penalties.

## 9. Life and AD&D Insurance: Life & AD&D Insurance is underwritten by LifeWise Assurance Company.

Beneficiary Designation: Subject to the terms of my Group Insurance Policy, I hereby designate or amend and revoke any former beneficiary named by me, and I now designate as Beneficiary:

Name (Last, First, MI,) \_\_\_\_\_ Relationship: \_\_\_\_\_ Beneficiary's Mailing Address \_\_\_\_\_

Name (Last, First, MI,) \_\_\_\_\_ Relationship: \_\_\_\_\_ Beneficiary's Mailing Address \_\_\_\_\_

**10. EMPLOYEE SIGNATURE** In applying for enrollment as indicated on this application, I declare that to the best of my knowledge all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. PHT, Willis, BSI, and The Insurance Companies may collect, use and disclose protected personal information (PPI) about each individual enrolled under this Application in order to carry out its routine business functions, which, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting, and conducting case management, care management and quality reviews. The Companies may also disclose PPI to state and/or federal agencies, or other third parties, as required by law.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

The medical plan imposes a preexisting condition waiting period. This means that if you have a medical condition before coming onto our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 90-day period. Generally, this 90-day period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 90-day period ends on the day before the waiting period begins. The preexisting condition waiting period does not apply to pregnancy, a child who is enrolled in the plan within 60 days after birth, adoption, or placement for adoption, nor to enrollees under the age of nineteen (19). You can reduce the length of this waiting period by the number of days of your prior "Creditable Coverage".

Definition: "Creditable Coverage" means any of the following coverage's: Group coverage (including FEHBP and Peace Corps); Individual Coverage (including student health plans); Medicaid; Medicare; State Children's Health Insurance Program (SCHIP); TRICARE; Indian Health Service or tribal organization coverage; state high risk pool coverage; employer-provided self-funded health plans; and public health plans. Creditable Coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance. Coverage is Creditable only if there has not been a gap in coverage exceeding 90 days. If you are declining enrollment for yourself or your Dependents (including your spouse or State Registered Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your Dependents' other coverage). However you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, or 60 days after the birth, adoption, or placement for adoption. If you previously declined enrollment in this plan for yourself or your Dependents because of coverage under a CHIP plan, you can enroll within 60 days of loss of such coverage. If you become eligible for premium assistance under a CHIP plan, you or your Dependents can enroll in this plan at any time once becoming eligible for premium assistance.

**IMPORTANT: THE FOLLOWING TERMS ARE A PART OF THIS APPLICATION. YOU MUST READ THEM CAREFULLY.  
DO NOT SIGN THE APPLICATION ABOVE UNTIL YOU UNDERSTAND THESE TERMS.**

I, the applicant (employee) on my behalf and on behalf of every covered Dependent listed on this form or added in the future hereby:

1. Agree that in the event any health care benefits provided to me or any covered Dependent by Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) and/or its representatives are the primary responsibility of Medicare or of any coverage for work-related injuries, illness or conditions or of any third party on account of any injury, illness, condition or damage, I will fully inform Health Net of Oregon and/or its representatives and will execute such assignments, liens or other documents which may be necessary to enable Health Net of Oregon and/or its representatives to recover the value of services provided. I further agree that in the event I, or any Dependent collects benefits, damages or reimbursement from Medicare or any other third party with respect to such injury, illness, condition or damage, after being fully compensated for my general damages, I will immediately reimburse Health Net of Oregon and/or its representatives to the full extent of services provided by Health Net of Oregon and/or its representatives in accordance with the group Agreement; and
2. Agree to be bound by each and every provision of the group Agreement (including all schedules and attachments which are a part of the group Agreement) as now in effect and as may be amended in the future, and agree that all my rights are as specifically set forth in the group Agreement; and
3. 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 Agreement; and
4. Acknowledge that Health Net of Oregon and/or its representatives Benefits are only available if obtained in compliance with all provisions of the group Agreement

Send this application to: PHT Service Center  
222 SW Columbia Street, Suite 600  
Portland, OR 97201  
service@pacifichealthtrust.com

The State of Washington adopted a standard Coordination of Benefits Regulation effective January 1, 1982. If you are separated or divorced from your spouse and have a Dependent child(ren), it is necessary for you to advise us of the following: Date of legal separation or final divorce decree, name of person awarded custody of Dependent(s), name of Dependent(s) involved, and name and address or parent required by courts to furnish medical insurance.

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