Individual and Family Policy Enrollment Form
Oregon

Before you get started

What you'll need to complete this enrollment form:

- A blue or black pen (if you're not filling it out electronically).
- Information, such as your old ID card, from any insurance company that currently or recently covered you or your family. This information is needed to determine creditable coverage.
- A copy of any documentation you may need to show legal guardianship.
- Your health insurance agent's information, if applicable.
- The name of your primary care provider for all family members enrolling.
- Your first month's premium payment (required before your policy will take effect).

You are eligible to enroll if:

- You are not receiving benefits under Medicare Part A. You are not enrolled in Medicare Part B, nor enrolled in a Medicare Choice or Advantage plan.
- You are a resident of the state of Oregon.
- Your spouse/domestic partner (if applicable) is your legal spouse/domestic partner.
- Your children (if applicable) are your natural or adopted children, under age 26 or you are their legal guardian.
- Your employer will not be paying, or reimbursing you, for any part of the premium.

Need help?

If you have questions about any part of this enrollment form, we'd be happy to help.

Call broker Dan Neils at 503-650-4325 or email me at danneils@gmail.com

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What Happens After You Submit Your Application

We'll begin processing your application, and in the coming weeks, you'll receive a few things from us. To get information faster, include your email address in your application.

1. You'll soon receive a Summary of Benefits and Coverage for the plan you chose.
2. Later, we'll send an email or postcard with information about using your plan and answers to common questions.
3. Look for your ID cards in the mail close to the date your plan begins.
4. We'll also mail your full policy.

Please keep a copy of this application for your records.

If you would like to enroll in a PacificSource Individual dental policy, please complete an Individual and Family Enrollment Form for Dental-only, instead.

1 What type of coverage would you like?

New Coverage

- For myself only
- For myself + my spouse/domestic partner
- For myself + my family
- For my child(ren) or legal dependent(s) only
- For myself (due to qualifying event)

Or **Change to My Current Coverage**

Current PacificSource ID No. ___________________

(This can be found on your ID card.)

- Add family member(s) (Complete section 7)
- Change my plan as shown below

Change will be effective on the first day of the month following the notification of change.

Qualifying Event ________________________________ Date of Qualifying Event _____/______/______

2 Choose a medical plan

For plan benefit information, please visit PacificSource.com/find-an-individual-plan or refer to our Oregon Individual and Family Plan brochure.

SmartChoice Network

Available in Crook, Deschutes, Jefferson, and Lane counties.

- Bronze HSA 6650
- Oregon Standard Gold
- Oregon Standard Silver
- Oregon Standard Bronze
- Catastrophic

Legacy Health Network

Available in Clackamas, Multnomah, Washington, and Yamhill counties.

- Bronze HSA 6650
- Oregon Standard Gold
- Oregon Standard Silver
- Oregon Standard Bronze
- Catastrophic

Catastrophic plan available if under 30 at start of plan year. If age 30 or over, visit Oregon Health Insurance Marketplace to see if your're eligible due to financial hardship or lack of affordable coverage.

This policy does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Separate pediatric dental care policies are available in the market. Please contact your insurance agent, PacificSource, or your state's insurance exchange if you wish to purchase a stand-alone dental care policy.

If you are attempting to purchase this plan outside of the exchange, you are not eligible to purchase this plan unless you currently have, or will obtain coverage with a qualified health plan (QHP)-certified pediatric dental plan with any carrier. This applies whether you are an adult or a child. We offer QHP-certified pediatric dental plans for which you are eligible to purchase through the exchange or directly with PacificSource. Please visit our website to review your options: PacificSource.com or contact your insurance agent for more information.

3 Choose a dental plan (If not enrolling in dental coverage, skip to section 4.)

- Dental Advantage 0-20-50 1000
- Dental Advantage 0-20-50 1500
- Kids Dental Advantage 0-20-50 (for members age 18 and under)

This policy includes pediatric dental coverage that meets the requirements of the Affordable Care Act.

4 Select a coverage date

What date would you like the coverage to begin? _____/_________ Mo/Yr.
Coverage will be active on the first of the month.

Enrolling myself and my family

List all family members you would like insured. Only your legal spouse, domestic partner, and dependent children are eligible.

***Race/Ethnicity** (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.

**Use of tobacco on average four or more times per week within the past six months. Includes all tobacco products, except for religious or ceremonial use.

5 Myself (Required)

If this is a child/dependent only policy, PacificSource requires the responsible parent or guardian to include their information.

Name (First, MI, Last) ______________________________

Gender (M/F) ____________ Social Security No. ____________________

Race/Ethnicity* ____________ Date of Birth (MM-DD-YY) ____________________

Marital Status Single Married Domestic Partnership

Physical Address ______________________________

City ____________ State ______ ZIP ________ County ____________

Phone ____________________ Email ____________________

Mailing Address (if different) ______________________________

City ____________________ State ______ ZIP ____________

Primary Care Provider Name ______________________________

Primary Care Provider Address ______________________________

Are you a current patient? Yes No

Do you use tobacco?** Yes No

Are you enrolled in a tobacco cessation program? Yes No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? Yes No

6 Spouse or Domestic Partner (Skip to section 7 if not enrolling a spouse or domestic partner.)

Name (First, MI, Last) ______________________________

Gender (M/F) ____________ Social Security No. ____________________

Race/Ethnicity* ____________ Date of Birth (MM-DD-YY) ____________________

Primary Care Provider Name ______________________________

Primary Care Provider Address ______________________________

Are you a current patient? Yes No

Do you use tobacco?** Yes No

Are you enrolled in a tobacco cessation program? Yes No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? Yes No

7 Dependent Child (Skip to section 8 if not enrolling dependents.)

Name (First, MI, Last) ______

Gender (M/F) ______ Social Security No. ______

Race/Ethnicity* ______ Date of Birth (MM-DD-YY) ______

Primary Care Provider Name ______

Primary Care Provider Address ______

Are you a current patient?	Yes	No
Do you use tobacco?**	Yes	No
Are you enrolled in a tobacco cessation program?	Yes	No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes?	Yes	No

Dependent Child

Name (First, MI, Last) ______

Gender (M/F) ______ Social Security No. ______

Race/Ethnicity* ______ Date of Birth (MM-DD-YY) ______

Primary Care Provider Name ______

Primary Care Provider Address ______

Are you a current patient?	Yes	No
Do you use tobacco?**	Yes	No
Are you enrolled in a tobacco cessation program?	Yes	No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes?	Yes	No

Dependent Child

Name (First, MI, Last) ______

Gender (M/F) ______ Social Security No. ______

Race/Ethnicity* ______ Date of Birth (MM-DD-YY) ______

Primary Care Provider Name ______

Primary Care Provider Address ______

Are you a current patient?	Yes	No
Do you use tobacco?**	Yes	No
Are you enrolled in a tobacco cessation program?	Yes	No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes?	Yes	No

Attach additional pages if needed   I have attached _____ pages

8 My Other Insurance Information

Please list the most recent health or dental insurance coverage you, or any people listed on this enrollment form, have had including commercial (employer group or individual insurance), Medicaid, Medicare, Medicare Advantage, Medicare supplemental or Pediatric Dental coverage.

No Prior Coverage

Name of other insurance company(ies) (include address and phone if available)

____

Type of Coverage (check all that apply)

Medical Vision Pediatric Dental Adult or Family Dental

Name(s) of individual(s) covered

____

Date coverage began ______/______/______ Date coverage ended ______/______/______

Is coverage active? Yes No Policy No. ______________________

If group insurance, name of group ______________________

Any other active coverage must be terminated before you can be issued a PacificSource individual and family plan.

9 Certify, Authorize, and Sign

Be sure to sign and date the enrollment form on this and the following page. Your spouse or domestic partner's signature is also required (if applicable) as is the signature of any child over the age of 18. You may request a free paper copy of your application and/or enrollment information by contacting our Commercial Enrollment and Billing Department via email at individual@pacificsource.com or by phone at (866) 695-8684.

Certification of Completeness and Correctness

I affirm that the answers given in this enrollment form are complete and correct. I am providing these answers as part of the enrollment form procedure required by PacificSource to enroll in its insurance coverage. I understand that if this enrollment form contains any intentional misrepresentation of material fact or fraud, PacificSource may modify or cancel the contract, and/or take any other legal action available by law. I will promptly inform PacificSource in writing if anything happens before my coverage takes effect that makes the information I have provided on this enrollment form incomplete or incorrect. I understand and agree that no coverage will be in force until accepted by PacificSource. If accepted, coverage will be in force as of the effective date determined by PacificSource. A representative of PacificSource may contact me to clarify answers on this enrollment form. Representations made by the enrollee are deemed to be representations made on behalf of each person covered under this policy. However, changes to the enrollment form will not be effective until approved in writing by the enrollee. An enrollment form received by PacificSource requiring alterations will be modified by amendment and sent to the enrollee for signature. As the enrollee, I understand I have the right to inspect the information in my file.

I (We) have reviewed and understand the authorization above.

Enrollee/Responsible Party/Guardian Signature ______________________ Date ____________

If enrolling in coverage:

Spouse/Domestic Partner Signature ______________________ Date ____________

Child age 18 or older Signature ______________________ Date ____________

Child age 18 or older Signature ______________________ Date ____________

Required if enrollee is a minor:

Printed name of Parent or Guardian ______________________________

Signature ______________________________ Date ______________

This enrollment form must be signed and dated. All fields must be completed for this authorization to be valid. Once accepted, PacificSource will provide the policyholder with a copy of this completed form with the policy.

10 Agent Authorization (Skip to section 11 if you are not working with an agent.)

I, the insurance agent, have not made any representations to the enrollee about any provisions, benefits, conditions, or limitations of the policy except through written material furnished by PacificSource. The enrollee has been informed that the effective date of coverage is assigned only by PacificSource. I hereby certify that information supplied to me by the enrollee has been truly and accurately recorded hereon.

Enrollee's Name (printed) ______________________________

Agent's Name (printed) Dan Neils Agape Insurance Services Inc.

PacificSource Agent No. P00226301

Agent's Signature Dan Neils Date ______________

11 How Do You Prefer to Pay for Future Premiums?

Your first month's premium must be received by check or money order before your policy will take effect. We will not accept third party payments except as required by federal law.

Please select your method of payment for future premium payments. Reminder: Your first month's premium can only be paid with a check or money order.

- Send me a paper bill by mail each month *(Skip to section 12)*
- Automatic withdrawal from my bank account (EFT). *The first month's payment cannot be made by EFT.*

We authorize and direct PacificSource Health Plans to withdraw funds as follows:

Amount of monthly withdrawal $__________ Withdrawals will occur on the 5th of each month.

Select one: Begin transfers on next available date Delay transfers until ______________(Mo.)

Bank information

Bank Name ______________________________

Account No. ______________________________ Routing No. ______________________________

Account Type

- Checking—Attach a voided check
- Savings—Attach a voided savings withdrawal slip

This authorization will remain in effect until termination by either party. If the individual policy premium changes due to a rate increase, alternate plan selection, or age change of the policyholder, this authorization will automatically be amended to authorize withdrawal of an amount equal to the new premium.

Policyholder's Name (printed) ______________________________ Date ____________

Signature of Bank Account Holder ___________________________ Date ____________

Important details about the automatic withdrawal of your monthly premiums:

- New accounts take 30 days to set up. If your policy is accepted and coverage starts sooner than your automatic withdrawal is set up, you may need to pay by check until the funds transfer is in place.
- Transfers occur on the 5th of each month. If the 5th falls on a weekend or a holiday, the transfer will occur on the next business day.
- Transfers will be made for the premium balance due.
- If EFT is not set up prior to the bill date of the second month, you may receive a paper bill for the second month.

12 | Are You Ready to Submit?

Are all sections filled in completely?
Have you attached requested paperwork (i.e., guardianship documentation, etc.)?
Did you select a policy coverage date on page 2?
Have you included a check or money order for your first month's premium payment?
Have you selected an ongoing payment option and attached a voided check if needed? (See section 11)

Send your signed, completed enrollment form and attachments to us by:

Email: Individual@pacificsource.com
Fax: (541) 225-3646
Mail: PacificSource Health Plans, PO Box 7068, Springfield, OR 97475-0068

Thank you for enrolling!

Office use only

Agent Note: If you would like me to review your enrollment form prior to submission for completeness, please email the enrollment to danneils@gmail.com or fax it to me at 503-863-3821.

If you have questions please call Dan at 503-650-4325