

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 health 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.**
- **Return the Enrollment Information page to your plan administrator.**

Disclosures Section

Social Security Numbers – Guidelines for Section 3

A new Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers to report information that the Secretary of the Department of Health and Human Services requires for purposes of coordination of benefits. In order for Medicare to coordinate Medicare payments with other insurance benefits properly, Medicare relies on the collection of both the Social Security Number (or Medicare Health Insurance Claim Numbers) and the Employer Identification Number. Therefore, please provide Social Security Numbers for each family member listed.

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. Your plan also excludes coverage for elective procedures, surgery for ear infections, removal of tonsils or adenoids, and sterilization for six months.

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, TRICARE, State Children's Health Insurance Program, and coverage through 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 Department at (541) 684-5583 or (866) 999-5583 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 PacificSource group health plan offered by your employer contains provisions that, in certain situations, may allow you or your family members to enroll in the plan later if you decline enrollment when you are first eligible. These special enrollment rights affect both you and your eligible family members.

The agreement between PacificSource and your employer may require all eligible employees to participate in the group health plan. In that case, you must enroll in the plan when you first become eligible. However, your family members may decline coverage, and they may enroll in the plan later if they qualify under Rule #1 or Rule #2 below.

Some employers have agreements with PacificSource allowing employees with other group health coverage to waive the PacificSource group coverage. In that case, both you and your family members may decline coverage when you are eligible. You and your family members may enroll in the plan later if you qualify under Rule #1 or Rule #2 below and a "Waiver of Coverage" form was submitted to PacificSource during your initial enrollment period or at the time you disenrolled in the group plan (see Waiving Health Coverage below).

Special Enrollment Rule #1

If you decline enrollment, you and your eligible family members may enroll in this plan during the annual open enrollment period. Please see your group administration for information on your annual open enrollment period.

Special Enrollment Rule #2

If you decline enrollment for yourself or your dependents (including your spouse or registered domestic partner) because of other group health insurance coverage, you or your family members may 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 your other group health 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 yourself and/or 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 or contact the PacificSource Customer Service Department at (541) 684-5582 or (888) 977-9299.

Waiving Health Coverage

If your employer had an agreement with PacificSource allowing employees to waive the PacificSource group coverage, both you and your family members may decline coverage when you are first eligible in accordance with that agreement. If you choose to decline coverage, you must complete a Waiver of Health Insurance Coverage form instead of this application.

To find out if your employer's plan allows employees to decline coverage, ask your health plan administrator. For more information on your plan's special enrollment provisions, please refer to your Member Benefit Handbook or contact the PacificSource Membership Department at (541) 684-5583 or (866) 999-5583.

BENTON COUNTY ENROLLMENT APPLICATION



PO Box 7068 • Eugene, OR 97401
(541) 684-5583 or (866) 999-5583
Membership Fax (541) 225-3642
Marketing Fax (541) 225-3645
www.pacificsource.com

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

Group Policy No. G0020194	Subgroup No.	Class No / Classification	
	<input type="checkbox"/> P001-BCDSA Traditional <input type="checkbox"/> P002-BCDSA CDHDHP <input type="checkbox"/> P003-Retiree <input type="checkbox"/> P004-COBRA <input type="checkbox"/> P005-Traditional- all others <input type="checkbox"/> P006-CDHDHP- all others	<input type="checkbox"/> 1001-BCDSA CDHDHP <input type="checkbox"/> 7001-BCDSA CDHDHP Retiree <input type="checkbox"/> 9001-BCDSA CDHDHP COBRA <input type="checkbox"/> 1003-BCDSA Traditional <input type="checkbox"/> 7003-BCDSA Traditional Retiree <input type="checkbox"/> 9003-BCDSA COBRA	<input type="checkbox"/> 1004-CDHDHP / All Others <input type="checkbox"/> 7004-CDHDHP / All Others Retiree <input type="checkbox"/> 9004-CDHDHP / All Others COBRA <input type="checkbox"/> 1005-Traditional / All Others <input type="checkbox"/> 7005-Traditional / All Others Retiree <input type="checkbox"/> 9005-Traditional / All Others COBRA

Section 1 – Employer Information

Employer/Group Name Benton County	Effective Date month _____ day _____ year _____
Date of Full Time Hire (required) month _____ day _____ year _____	Number of Hours Work Per Week
	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Other _____

Section 2 – Employee Information

Employee Last Name	First Name	M.I.
Mailing Address		
City	State	Zip code
Home Phone No.	E-Mail Address	Job Title
Date of Birth month _____ day _____ year _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Registered Domestic Partner
Type: <input type="checkbox"/> New Applicant–Employee <input type="checkbox"/> Add dependents <input type="checkbox"/> COBRA or Continuation qualifying event _____ Due To: <input type="checkbox"/> New Hire <input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Registration <input type="checkbox"/> Birth <input type="checkbox"/> Adoption* <input type="checkbox"/> Court Order* <input type="checkbox"/> Involuntary loss of other coverage* <input type="checkbox"/> Open Enrollment Date Qualifying Event Occurred: month _____ day _____ year _____ <i>*Attach proof of qualifying event</i>		

Section 3 – Family Information

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

Name	Sex	Birth Date	Social Security Number <i>(Required–refer to disclosure)</i>
Employee			
Spouse / Registered Domestic Partner			
Child			
Child			
Child			
Child			
Child			
Child			
Child			

Your relationship to any family member above with a different last name:

Primary language spoken in household: English Español Other: _____

Para asistirle en español, por favor llame al numero (800) 624-6052, ext. 1009, de Lunes a Viernes, 8:00 a.m. hasta 5:00 p.m.

Section 4 – 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/or** attach proof with dates of coverage.

Name	Insurance Carrier	Date of coverage	Will Coverage Continue?	Type of Coverage
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree

Married or registered – Is your spouse or domestic 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
			<input type="checkbox"/> Age <input type="checkbox"/> ERSD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement
			<input type="checkbox"/> Age <input type="checkbox"/> ERSD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement

Section 5 – 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 PacificSource 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
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Section 6 – 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.

Employee Signature

Date



PacificSource
HEALTH PLANS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

FROM: _____ (the employer)

ADDRESS: _____ PHONE: _____

TO: _____

What This Notice is About: You are receiving this notice because you recently became covered under the company's group health plan, hereafter referred to as "the Plan." This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage.

This notice explains COBRA continuation coverage in general, when coverage may become available to you and your family, and what you need to do to protect your right to receive it. This notice gives only a summary of your COBRA continuation rights. For more information about your rights and obligations under the Plan and under federal law, you should review your Member Benefit Handbook or Summary Plan Description, or contact the Plan Administrator.

COBRA Continuation Coverage: COBRA continuation coverage is a continuation of the Plan's coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are responsible for payment of COBRA continuation coverage premium.

Qualifying Events: If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan due to one of the following qualifying events:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan due to one of the following qualifying events:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced from your spouse. If an employee cancels coverage for his or her spouse in anticipation of a divorce and a divorce later occurs, then the divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the plan administrator within 60 days after the divorce and can establish that the employee canceled the coverage earlier in anticipation of the divorce, then COBRA coverage may be available for the period after the divorce.

Your dependent children will become qualified beneficiaries if they will lose their coverage under the Plan due to one of the following qualifying events:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced; or
- (6) The child stops being eligible for coverage under the Plan as a “dependent child.”

To Retirees Covered Under the Plan (when applicable): Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If the employer sponsoring the Plan files a proceeding in bankruptcy, and that bankruptcy causes retired employees covered by the Plan to lose their coverage, then those retired employees are qualified beneficiaries. Retired employees’ spouses and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Employer Notification Requirements: The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified in a timely manner that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy by the employer (for covered retirees only), or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

Your Notification Requirements: For other qualifying events (divorce or a dependent child’s losing eligibility for coverage as a dependent child), *you must notify* the Plan Administrator. The Plan requires you to notify the Plan Administrator **in writing** within 60 days after either the qualifying event or the loss of coverage, whichever is later, using the procedure specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

Notification Procedures: Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or deliver your notice to the Plan Administrator. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must include the name and address of the employee covered under the Plan and the names and addresses of the qualified beneficiaries. Your notice must also name the qualifying event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Electing COBRA Continuation Coverage: Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage within the allotted time, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. **If you, your spouse, or your dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.**

Coverage Periods: COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension: If you or anyone in your family covered under the Plan is determined by Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months total. You must make sure that the Plan Administrator is notified in writing of the Social Security Administration’s determination within 60 days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension: If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum period of coverage of 36 months total. This extension is available to the spouse and dependent children if the former employee dies or gets divorced. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure the Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. In regards to a second qualifying event, you must follow the notification procedures outlined above. In case of divorce, your notice must include a copy of the divorce decree. If notice is not provided

in writing to the Plan Administrator within the required 60-day period, then there will be no extension of COBRA continuation coverage due to a second qualifying event.

Medicare Extension for Spouse and Dependent Children: If a termination of employment or a reduction of hours is the qualifying event and it occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end three years from the date the employee became entitled to Medicare.

Newborn and Adopted Children: A child born to, adopted by, or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan through special enrollment and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

Alternative Recipient under a Qualified Medical Child Support Order (QMCSO): A child who is receiving benefits under the Plan pursuant to a QMCSO received by the Plan Administrator during the covered employee's period of employment is entitled to the same rights under COBRA as a dependent child of the covered employee, regardless of whether the child would otherwise be considered a dependent.

If You Have Questions: If you have questions about your COBRA continuation coverage, you should contact your Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes: In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Names, Addresses, and Telephone Numbers:

Plan Administrator Name: _____ Phone: _____

Address: _____

COBRA Administrator Name (if different from Plan Administrator): _____

Address: _____ Phone: _____