CC: Payroll _______
Datatel _______
Regence BC/BS _______
KP _______

Willamette University
Medical/Dental Enrollment/Change Form

TYPE: ___ ENROLL ___ CHANGE ___ CANCEL
DESCRIBE: ______________________________

Administrator Use Only
Hire Date: ______________________
Effective Date: ______________________
Date of Qualifying Event: ______________
Number of Hrs. Worked: ______________
☐ **New Employee** ☐ **Open Enrollment**
☐ **Add dependent**: ☐ birth; ☐ marriage; ☐ adoption; ☐ loss of coverage; ☐ legal guardianship; ☐ other
☐ **Cancel dependent**: ☐ divorce; ☐ over 23; ☐ other coverage; ☐ death
☐ **Employee Termination**
☐ **Name /Address change**
☐ **Other**
☐ **Transfer to COBRA:** ☐ Over age; ☐ Termination; ☐ Divorce; ☐ Death; ☐ Reduction in Hrs.; ☐ Disability

Administrator's Signature: ______________________

Name (Last, First M.I.): ______________________________ **Sex: M / F**
Home Address: ______________________________**Apt. No:** _____ **Home Phone:** ____________
City: ______________________ **State:** ______ **Zip:** ________ **Work Phone:** ______________
Social Security #: __________________ **Date of Birth:** ____________ **Marital Status:** ______

MEDICAL/VISION/PRESCRIPTION:
☐ PEHT PPO: *Regence* Preferred Provider Network (Group number 4147)
☐ Kaiser Permanente HMO Plan (Group & Subgroup number 2014-001)

☐ Employee Only ☐ Employee + 1 ☐ Employee + family

DENTAL:
☐ PEHT FFS **OR** ☐ Kaiser Permanente HMO Plan (Group & Subgroup number 2014-006)

☐ Employee Only ☐ Employee + 1 ☐ Employee + family

If you elected Kaiser Permanente: What percentage of time do you work in the Kaiser Permanente Northwest service area? ________ %
Have you or your dependents previously had Kaiser Permanente coverage in this region? ☐ Yes ☐ No
If yes: Name: ______________________ Former name, if different: ____________________________ Health Record number: ____________

Med./ Vis. ✓	Den. ✓	Name: (Last, First M.I.)	Relationship	Social Security Number	Sex	Date of Birth	Disabled Yes/No	FT Student
			Self				Yes / No	Yes / No
			☐Spouse ☐Domestic Part*				Yes / No	Yes / No
			Child				Yes / No	Yes / No
			Child				Yes / No	Yes / No
			Child				Yes / No	Yes / No
			Child				Yes / No	Yes / No
			Child				Yes / No	Yes / No

Do you or any of your dependents applying for coverage have coverage now through ANY health care plan? ☐ Yes ☐ No
If you or your dependents have coverage through any health care plan, and this coverage will continue, you MUST complete the following: Other Insurance: Ins. Co. Name: ____________________ Policy #: ____________________ Policy Holder's Name: ____________________
Person's Covered: __________________________ Date Coverage Began: ___________ Date Coverage Ends: ___________ ***(OVER)***

Refusal of insurance: I understand that if I refuse coverage, my ability to obtain benefits under health plans may be restricted by the guidelines set forth by each carrier.

I decline the following coverage(s) for myself: ☐ Medical/Vision/Prescription ☐ Dental I am declining due to other coverage: ☐ Yes ☐ No
I decline the following coverage(s) for my dependents: ☐ Medical/Vision/Prescription ☐ Dental I am declining due to other coverage: ☐ Yes ☐ No
Dependents declining: ☐Spouse Only ☐ Spouse & Child(ren) ☐ Child(ren) Only

APPLICATION AGREEMENT:

- ✓ I authorize my employer to deduct from my salary or wages, if applicable, the necessary premiums for the coverage requested. My signature also verifies the accuracy of the information on this form.
- ✓ I understand all premiums to be paid by me will be deducted on a pre-tax basis from my paycheck unless I contact the payroll department and request otherwise. **Premiums related to coverage for domestic partners and their children, unless a legal tax dependent, will not be deducted with pre-tax dollars. Further, such benefits may also be treated as taxable income. Please consult with your tax advisor for more information.*
- ✓ Changes in coverage during the plan year may be made with the occurrence of a qualifying event, as defined by the internal revenue code, within 31 days of the event. Requested changes must be consistent with the nature of the qualifying event. This includes additions, cancellations/removal or dependents termination of coverage or any other changes.
- ✓ If I decline all or a portion of any of the offered benefits, I understand that I will be subject to the restrictions upon subsequent applications and may need to provide satisfactory evidence of insurability.
- ✓ Each of the benefits plans is governed by an official plan document. If any discrepancies arise between any summaries and the official plan documents, the official plan document will be regarded as the final authority.

RELEASE OF INFORMATION:
Health Information requested or disclosed may be related to treatment or services performed by:

- ✓ A physician, dentist, pharmacist, or other physical or behavioral health care practitioners;
- ✓ 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, diagnostics 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 hereby verify that all the information specified above is accurate and complete. I have also read and understood the Application Agreement and Release of Information.

X Applicant's Signature: ______________________________ Date: ____________________

After completing, please print and sign this form and return it to the Human Resource Office.
Your application is not complete until the printed and signed version has been received by the Human Resources Office.

Revised 1/21/2009