PacificSource Enrollment

Questions? Call us at 1.888.957.5001

Tips for completing the application:

- Please read everything carefully and answer all questions honestly. This document becomes part of your health insurance contract.
- Please complete all sections to the best of your ability.
- The section about your health information is to make sure that you get all the support care you may need. It is not required to complete this section.

Payment Options:

- **Monthly Bank Draft (EFT):** Please complete authorization section carefully and attach a voided check. (deposit slip does not work!)
- **Direct Bill:** Check box and you are done.

Final Checklist Before Mailing:

- All sections completed?
- Signed and Dated
- Voided check if selecting the automated monthly withdrawal

Send Completed Application to:

First Choice Health Insurance, Inc.
2000 W Harvard Aveneue #100
Roseburg OR 97471
FAX: 541.541.440.6944
Email: aprilm@ehealthlink.com

****SENDING TO PACIFICSOURCE WILL DELAY PROCESSING****

PacificSource Health Plans
Individual and Family Dental Policy Enrollment Form

Thank you for choosing PacificSource!
You may also enroll online at **PacificSource.com/find-an-individual-plan**.

1. What you'll need to complete this enrollment form:

- A blue or black pen.
- Information, such as your old ID card, from any insurance company that currently or recently covered you or your family.
- A copy of any documentation you may need to show legal guardianship.
- Registration or Affidavit of Domestic Partnership to be enrolled as a qualified domestic partner.
- Your health insurance agent's information, if applicable.
- Your first month's premium payment (required before your policy will take effect).

2. You are eligible to enroll if:

- ☐ You are a resident of the state of Oregon.
- ☐ Your spouse/domestic partner (if applicable) is your legal spouse or registered 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.
- ☐ You haven't had other PacificSource Individual dental coverage within the last 24 months.

3. What type of coverage would you like?

New Coverage

- ☐ For myself only
- ☐ For myself and my spouse
- ☐ For myself and my qualified domestic partner
- ☐ For myself and my family
- ☐ For my child(ren) or legal dependent(s) only

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

OR

Change to My Current Coverage

Current Member ID #_____

- ☐ Add family member(s)
- ☐ Change my plan as shown below

Need help? ***If you have any questions about any part of this enrollment form, we'd be happy to help. You can reach an Individual Sales Representative at (855) 330-2792.***

Choose a plan (check one):

If yes, please choose a Dental plan:

☐ Kids Dental Advantage 0-20-50 ☐ Dental Advantage Essential Core ☐ Dental Advantage 0-20-50

What date would you like the coverage to begin? ☐1st or ☐15th of_____/_____Mo/Yr

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

If you would like to enroll in a PacificSource Individual medical policy, please complete an Individual and Family Enrollment Form, instead.

4. 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.

Myself						
(First, MI, Last)	Gender (M/F)	Race/ Ethnicity*	Social Security Number	Date of Birth (MM-DD-YY)		
Marital status: ☐ Single ☐ Married ☐ Registered Domestic Partnership ☐ Unregistered Domestic Partnership (affidavit of domestic partnership required)				Email:		
Address:	City:			State:	Zip:	County:
Mailing address (if different):				Phone:		

Spouse or domestic partner				
(First, MI, Last)	Gender (M/F)	Race/ Ethnicity*	Social Security Number	Date of Birth (MM-DD-YY)
Dependent child				
(First, MI, Last)	Gender (M/F)	Race/ Ethnicity*	Social Security Number	Date of Birth (MM-DD-YY)
Dependent child				
(First, MI, Last)	Gender (M/F)	Race/ Ethnicity*	Social Security Number	Date of Birth (MM-DD-YY)
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(First, MI, Last)	Gender (M/F)	Race/ Ethnicity*	Social Security Number	Date of Birth (MM-DD-YY)
Dependent child				
(First, MI, Last)	Gender (M/F)	Race/ Ethnicity*	Social Security Number	Date of Birth (MM-DD-YY)
Dependent child				
(First, MI, Last)	Gender (M/F)	Race/ Ethnicity*	Social Security Number	Date of Birth (MM-DD-YY)

Attach additional pages if needed. ☐ I have attached________page(s).

5. My Other Insurance Information

Do you, or any people listed on this enrollment form, have other active dental insurance coverage, including Medicare, Medicare Advantage, or Medicare supplemental coverage? ..... ☐Yes ☐No

Name of other insurance company (include address and phone number if available):	
Name(s) of individual(s) covered under the policy:	
Date coverage began: ___/___/_____ Date coverage ended: ___/___/_____ ☐Coverage is still in effect	Policy number: If group insurance, name of group:

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

6. Certify, Authorize, and Sign

Be sure to sign and date the enrollment form. Your spouse's or domestic partner's signature is also required (if applicable) as is the signature of any child over the age of 18.

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 their 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 may at any time request a free paper copy of my application and/or enrollment information by contacting the Commercial Enrollment and Billing Department via email at individual@pacificsource.com or by phone at (855) 330-2792. Electronic communications are offered as a convenience only.

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

_____ _____
Enrollee/responsible party/guardian Signature — Date

_____ _____
Spouse's/Domestic Partner's Signature (if enrolling in coverage) — Date

_____ _____
Signature of child age 18 or older (if enrolling in coverage) — Date

_____ _____
Signature of child age 18 or older (if enrolling in coverage) — Date

Required if enrollee is a minor:

_____ _____ _____
Signature of (check one) ☐Parent☐Guardian — Date — Printed Name of Parent or Guardian

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

7. Producer Authorization

I, the insurance producer, 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)

John Gridley
Producer's Name (printed)

P00053401
PacificSource Producer Number

Producer's Signature

Date

8. How Do You Prefer to Pay?

We must receive your first month's premium before your policy will take effect. We will not accept third party payments, except as required by federal law.

☐ Send me a paper bill by mail each month

☐ Through automatic withdrawal from my bank account (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 the next available date ☐Delay transfers until_____(month)

Bank information:

Bank name:_____ Account number: _____

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 (please print)

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.

9. Are You Ready to Submit?

- ☐ Are all sections filled in completely?
- ☐ Have you attached any requested paperwork (such as guardianship documentation, Affidavit of Domestic Partnership, etc.)?
- ☐ Did you select a policy effective date on page 2?
- ☐ Have you selected a payment option and attached a voided check if needed? (See section 9)
- ☐ Have you included your first month's premium payment?

10. Submit

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