Regence BlueCross BlueShield of Oregon

An Independent Licensee of the Blue Cross and Blue Shield Association

OSBA EMPLOYEE ENROLLMENT FORM

OREGON SCHOOL BOARDS ASSOCIATION

School District _____

☐ New Enrollment - Date of Full-Time Hire/Rehire (mm/dd/yyyy) _____

☐ Change of Existing Enrollment

FOR EMPLOYER USE ONLY:

Group No. 092000 ___ ___ ___

Package No. _____

Requested Effective Date _____

FOR PLAN USE ONLY:

Alternate ID Number _____

Please complete all information on this form:

Employee's Last Name *	Employee's First Name *	Middle Initial	e-mail address	Social Security No.	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female

Home Address & Apt. No./Mailing Address	City	State	Zip Code	Home Phone	Business Phone	☐ Married ☐ Domestic Partner ☐ Divorced ☐ Single ☐ Widow
				( )	( )	

Dependents to be enrolled:

Plan Use	Full Last Name *	Full First Name *	Middle Initial	Social Security Number	Date of Birth (mm/dd/yyyy)	Gender M/F	Relationship to Employee	Enrolling in:
Employee 1	Same as Above	Same as Above	Same	Same as Above	Same as Above	Same	Self	☐ Medical ☐ Dental
Spouse 2					/ /			☐ Medical ☐ Dental
Child 3					/ /			☐ Medical ☐ Dental
Child 4					/ /			☐ Medical ☐ Dental
Child 5					/ /			☐ Medical ☐ Dental
Child 6					/ /			☐ Medical ☐ Dental
Child 7					/ /			☐ Medical ☐ Dental

* List names as they should appear on your identification card.

If changing existing enrollment, indicate reason below:

☐ Name Change - Former name _____

☐ Address Change

☐ Add Dependent due to:
- ☐ Open Enrollment
- ☐ Marriage - Date _____
- ☐ Newborn
- ☐ Loss of Coverage - Date _____
- ☐ Other _____

☐ Delete Dependent - Reason _____

Name(s) _____

If applicable - Final date of divorce _____

List any of the above dependent(s) attending a boarding school, accredited college or university. Include the name and location of the school.

If you are applying due to loss of other health insurance coverage, please include a copy of your certificate of coverage and complete the following:

Policy No.	Identification No.	Name of Insurance Company/Phone No.	Date Coverage Began	Date Coverage Ends

Coverage was: ☐ Group ☐ Individual ☐ Medical ☐ Dental

For: ☐ Self Only ☐ Family as listed above ☐ Other _____

Reason for Loss of Coverage

Please Complete and Sign the Reverse Side

In the columns below (A, B, and C), please check applicable medical and dental choices based on the plan(s) your employer has purchased.

A) Medical Choice:	B) Deductible Choice:	C) Dental Choice:
☐ Plan A	☐ $100 ☐ $300 ☐ $200 ☐ $500	☐ Plan 1 ☐ Plan 2 ☐ Dentacare (Willamette Dental Group - requires services only at Willamette Dental Group offices) ☐ Dental not applicable
☐ Plan B	☐ $100 ☐ $300 ☐ $200 ☐ $500	
☐ Plan C	☐ $500 ☐ $1000	
☐ Preferred Provider Plan		
☐ Regence HSA Qualified Plan		

Classification:

☐ Administrative ☐ Certified ☐ Classified ☐ Full-Time ☐ Part-Time ☐ Retiree Job Title _____

OTHER ENROLLMENT INFORMATION (This is not a waiver of coverage. This information is required for payment of claims.)

Do you or any family members enrolling have other group health insurance and/or Medicare? ☐ Yes ☐ No If yes, check the types of coverage: ☐ Medical ☐ Prescription ☐ Vision ☐ Dental ☐ with Orthodontia

If you or any family members listed on this application have Medicare, is coverage: ☐ Part A ☐ Part B

Member	Effective Date	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement

Are you or any family members covered by Medicare disability? ☐ No ☐ Yes - ☐ Part A ☐ Part B

Please also complete the following:	Name of Policyholder	Birthdate of Policyholder	Insurance Carrier	Policy No.	Carrier Phone No.
					( )

First Names of Persons Covered

Is the insurance of any above dependents affected by a divorce decree/court order? ☐ Yes ☐ No

If yes, please include portion of decree that shows responsibility for medical expenses.

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health-care treatment, payment or for the purpose of 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 health-care 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). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence BlueCross BlueShield of Oregon may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available by telephone request or on our Web site at www.or.regence.com.

▶ _____ _____ _____

Employee's Signature | Date | Employee's Full Name (please print clearly)