Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Application For Enrollment/Change (for groups 101+)

Please print in black ink. Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." **The form must be signed and dated or it will be returned.** The five boxes directly below should be completed by the Group Administrator.

Health Group Number	Subgroup	Class	Group Name	Requested Effective Date
1 0 0 2 8 2 9 6			MEDFORD SCHOOL DISTRICT	

Employee Last Name	First Name	Middle Initial

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

NEW ENROLLMENT

New Enrollment due to:

☐ New Group ☐ Open Enrollment ☐ New Hire ☐ Rehire-Date ________________

☐ Satisfaction of non-time-lapse based eligibility criteria-Date ________________

Members Current Employment Status:

☐ Actively working

☐ Retiree — Retirement Start Date ________________

☐ COBRA Participant — COBRA Start Date ________________

☐ Long Term Disability — Long Term Disability Start Date ________________

CHANGE

Change:

☐ Add employee with/without dependent(s) ☐ Add dependent(s) only-Employee must already be enrolled ☐ Plan Selection

Change due to:

☐ Birth ☐ Marriage/Oregon-Certified Domestic Partnership ☐ Adoption

☐ Open Enrollment ☐ COBRA Coverage Exhausted ☐ Loss of Eligibility on another plan

☐ Court Order ☐ Add Eligible Domestic Partner ☐ Loss of Medicaid or CHIP

☐ Eligibility for group premium assistance under Medicaid or CHIP

Date of Change Event

Demographic Information Change:

☐ Name Change ☐ Address Change

CANCELLATION AND/OR COBRA OR NON-COBRA CONTINUATION ENROLLMENT

Cancellation: (select cancellation reason and enter cancellation date below)

☐ Cancel Employee and All Dependent(s) ☐ Cancel All Dependent(s)

☐ Cancel Dependent(s) - List: ________________

Group Administrator signature is required below if cancellation is being requested with an effective date prior to the date this form will be received by Regence BlueCross BlueShield of Oregon.

COBRA or Non-COBRA Continuation Enrollment:

☐ COBRA ☐ Non-COBRA Continuation

Cancellation Reason/COBRA or Non-COBRA Continuation Qualifying Event:

☐ Enrolled child no longer eligible ☐ Death ☐ Medicare Eligibility ☐ Military Leave

☐ Divorce, annulment, or termination of Domestic Partnership ☐ Reduction of Hours

☐ Termination of non-employment based membership in the covered group (e.g., union)

☐ Termination of Employment ☐ Other Medical Coverage ☐ Other reason ________________

Date of Cancellation Event

This confirms that any employee and/or dependent for whom retroactive cancellation for administrative delay is requested on this form did not have an expectation of coverage after the requested cancellation effective date and did not pay premium for coverage beyond the requested cancellation effective date.

Group Administrator Signature ________________ **Date** ________________

Application For Enrollment/Change (continued)

SECTION 2 - PLAN SELECTION

MEDICAL: ☐ Preferred 800 ☐ Preferred 1200 ☐ HSA 1600 - **Please complete the below section**

***Health Savings Account:** If your employer has decided to partner with HealthEquity (Regence's preferred HSA banking partner), Regence will open an HSA bank account for you.

You will be able to make payments to your medical providers from your HSA with ease when you allow Regence to send claims to HealthEquity.

☐ Yes, I authorize Regence to share my claims information with HealthEquity for the purpose of simplifying the provider payment process from my HSA bank account.

For additional disclosures and information, view the HealthEquity terms and conditions at http://healthequity.com/legal.aspx. Terms and conditions of the Health Savings Account will be mailed with your HealthEquity HSA Visa Card.

☐ No, do not share my enrollment or claims information with HealthEquity.

If you are opting to include an HSA savings account in this application, you will need to provide your Social Security Number in Sections 3 and 4 of this application.

***DENTAL:** ☐ Traditional Dental ☐ Willamette Dental ☐ No Dental

***Please confirm renewal and dental plan availability with your Group Administrator.**

SECTION 3 - EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial
Mailing Address	City, State, and ZIP Code	
Physical Address	City, State, and ZIP Code	

Daytime Telephone Number ( )	E-mail Address	Primary Language

Date of Birth	Gender: ☐ Female ☐ Male	Social Security Number	Original Date of Hire

Full-time Date of Hire	Hours Per Week	Marital Status: ☐ Single ☐ Divorced ☐ Non-Certified Domestic Partner ☐ Married or Oregon-Certified Domestic Partner

SECTION 4 - ENROLLING DEPENDENTS

Gender	Name(s) of Individual(s) to be Covered (First, Middle, Last)	Medical	Dental	Relationship to Applicant	Social Security Number for each Individual Covered	Birthdate Mo/Day/Yr
☐ F ☐ M		☐	☐			/ /
☐ F ☐ M		☐	☐			/ /
☐ F ☐ M		☐	☐			/ /
☐ F ☐ M		☐	☐			/ /
☐ F ☐ M		☐	☐			/ /
☐ F ☐ M		☐	☐			/ /

If you need extra space, please request an additional form from your group administrator.

SECTION 5 - CHILD CUSTODY INFORMATION

If natural or adoptive parents are separated or divorced, please indicate below who has legal custody of the child(ren). Please use additional paper if needed. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the health care insurance of the dependent(s) so that the carrier can determine whose coverage is primary.

Name of Child(ren)	Father	Mother	Joint	Other	Date awarded	Who is required to provide coverage for the child(ren)?
	☐	☐	☐	☐		
	☐	☐	☐	☐		
	☐	☐	☐	☐		

SECTION 6 - CURRENT AND PRIOR COVERAGE

Name of Covered Members: Self and Dependent(s)	Insurance Company (Name, Phone Number, and Policy Number)	Date of Coverage	Will coverage continue while on this Plan?	Product and Coverage Type
	Name: Phone: Policy Number:	To: From:	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: Policy Number:	To: From:	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: Policy Number:	To: From:	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: Policy Number:	To: From:	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: Policy Number:	To: From:	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD

Reason for Medicare Entitlement (if applicable): ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

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SECTION 7 - CONSENT TO ELECTRONIC DISTRIBUTION

Regence BlueCross BlueShield of Oregon (Regence) is engaged in efforts to increase the use of technology and curb the use of paper. In support of those efforts, Regence has established a process under which communications to members can be posted to a secured account that a member establishes on Regence.com, with e-mail notice provided to a member-supplied e-mail account when a new communication is posted.

By my signature below and unless I have expressly rejected electronic distribution by marking the checkbox below, I consent, on behalf of myself and any covered dependents, to the electronic distribution of communications related to the coverage applied for and understand that:

- To access electronically distributed communications, I and each of my covered dependents will need to establish Regence.com accounts for use on a system meeting the outlined requirements and I represent that we each have and will continue to have access to such a system or systems.
- Not all member communications are currently available electronically, but agree that my consent will apply to the following materials available, or as they become available, for electronic distribution, (i) notices of enrollment and/or effective date, (ii) acknowledgements of receipt of claims, requests for additional information related to claims and notices of associated delays in processing, and determinations on submitted claims, (iii) general informational disclosures required by law, including but not limited to notices of rights under the Women's Health and Cancer Rights Act, state patient protection acts, and privacy laws, (iv) communications regarding complaints, grievances, or appeals, including but not limited to acknowledgements of receipt, requests for additional information and notices of associated delays, and notices of determinations, (v) summaries of benefits and coverage and uniform glossary of terms, (vi) notices of benefit changes or policy modifications, (vii) renewal information, (viii) notices of discontinuation, (ix) notices of termination and continuation coverage rights, (x) certificates of creditable coverage, (xi) billing notices and statements.
- Until a type of communication can be distributed electronically, a paper copy will be provided.
- Once available in electronic form, any electronically distributed communications may be printed from the Regence.com account where they are posted, or a paper copy of any particular communication may be requested at any time using Regence.com or by contacting Regence Customer Service at the number provided on my ID card.
- I may change the e-mail address for receipt of notice of electronic distributions or withdraw consent (returning to paper distribution) at any time and without charge using Regence.com or by contacting Regence Customer Service as described in the previous bullet.

The e-mail address for receipt of notice of electronic distributions is ______________________________

☐ I do not want electronic distribution. Unless my consent is not required for an electronic distribution, I elect to receive communications related to this coverage in a paper format.

Applicant's Signature ______________________________ Date ______________

SECTION 8 - APPLICANT SIGNATURE

I hereby apply for enrollment, change, or cancellation of coverage as indicated above. I understand any coverage will be under the master contract between Regence and my employer and I agree to the terms and conditions of that master contract. I agree to abide by the Employer's enrollment provisions and certify that all those who I seek to enroll, including myself, meet the eligibility criteria as agreed to by the Group in the master contract. I understand that coverage cannot start until after I have served an eligibility waiting period agreed to by the employer as recorded on Regence's records.

An eligible individual not listed on this application will be considered as waiving coverage. I acknowledge that I have had the opportunity to enroll, but do not wish to make application for any eligible individual not listed. In waiving coverage, I am aware that waiving individuals (including me, if I am waiving) may enroll later only at my group's anniversary, unless qualified for a Special Enrollment Period.

SECTION 8 - APPLICANT SIGNATURE (continued)

If I have waived enrollment for myself or any of my dependents (including my eligible spouse or domestic partner) because of other health insurance or group health plan coverage, I may in the future be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage or domestic partnership, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage or domestic partnership, or within 60 days after the birth, adoption, or placement. To obtain more information about these rules, please call 1 (800) 505-6801.

Except by express amendment signed by an officer of Regence, no person, including, but not limited to any independent producer, agent, or employee of Regence or of my employer, may change the terms of the master contract, any of its amendments, or this application and no person may waive the requirement that I answer all questions on this application completely and accurately. I understand that this application will become part of the contract between Regence and my employer.

I authorize my employer to act as my agent in all matters of administration of the group coverage, and acknowledge that my employer is in no way acting as agent for Regence. I agree to pay the appropriate premium rates for myself and my enrolling dependents in advance, and authorize payroll deduction of premiums as required.

I authorize any source to release to Regence, any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that Regence may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed 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). This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

I understand there may not be participating providers in all specialty areas.

I have provided these answers as part of the application procedure required by Regence to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence will rely on each answer in making coverage and rating determinations. For the protection of all members, fraud or misrepresentation of material fact by me for the purposes of defrauding Regence may result in Regence taking any action allowed by law or contract, including termination or rescission of coverage and/or denial of benefits, and/or could subject me to prosecution for insurance fraud.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform Regence in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Applicant's Signature ________________________ Date ______________

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