



Enrollment Application and Change of Information Form

Please complete both sides of this form and sign on the back. Please type or print legibly in ink. Thank you!

Group/Employer Name	Group # (complete if known)	Division # or Name (complete if known)	Date of Employment

Employee Name First M.I. Last	Birth date	Gender	Employee Social Security #
		<input type="checkbox"/> M <input type="checkbox"/> F	
Employee Mailing Address Address	City	State	Zip
			()

Coverage:

Dental Coverage

Type of Application:

New Enrollment or Rehire
Effective Date: _____

Open Enrollment

COBRA - complete section on back

Changes:

Address Change

Name Change
Effective Date: _____
New Name: _____
Old Name: _____

Add Dependent(s) - List dependent(s) to add in dependent section and qualifying event date*.
Newborn Birth date: _____
Adoption Date: _____
Marriage Date: _____
Court-Appointed Guardian
Date: _____
Loss of Group Coverage
Date: _____

* Dependent adds require a qualifying event date unless added during open enrollment.

Terminate Dependent(s) - List dependent(s) being terminated in dependent section, date and reason.
Term Date: _____
Reason: _____

Dependent information (If terminating dependents, please list those dependents to remove from coverage)

Name First M.I. Last	Birth date	Gender	Relationship (Spouse, child, ward, etc.)
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	

Other Insurance (Coordination of Benefits)

Will employee or any dependents have **other** dental insurance? Dental No Other Dental Insurance

OVER



ODS Enrollment Application

It is VERY important that the employee sign and date below. Thank you!

Full-time Students

Complete this section if you have eligible dependents who attend an accredited school college or university on a **full-time basis**.

<u>Dependent Name</u>	<u>Full-Time Student</u>	<u>School Name</u>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

COBRA
(not for current employees)

Qualifying Events:

Divorce

End of employment

Loss of dependent child status

Reduction in hours

Other _____

Event Date: _____

Covered Dependent Children Definition

An unmarried child is eligible for coverage if he/she meets the dependent eligibility requirements of the employees plan. See your Member Handbook for details.

The following are eligible dependent children:

- Your natural child
- Your step-child, foster or adopted child
- Children placed with you for adoption
- Newborns born to a covered dependent, for whom you are financially responsible (legal guardianship is required for coverage after the first 31 days)
- Children related by blood or marriage for whom you are the legal guardian (You will need to attach a signed court order showing legal guardianship.)

Please read and sign below.

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).

This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 503-243-4492.

REQUIRED

X _____ Date: _____