2020-21 Concepts in Community Living Benefit Enroll/Waive Form (#7)

Plan Year: October 1, 2020 through September 30, 2021

A) EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security Number	
Street/PO Box	**City**	**State**	**Zip**	**# Hours Worked per Week:**
Marital Status ❒ **Single** ❒ **Married** ❒ **Divorced**	**Gender** ❒ **Male** ❒ **Female**	**DOB (*MM/DD/YYYY*)**	**Phone:** ❒ **Home** ❒ **Cell**	**Ethnicity:**

B) ENROLLMENT TYPE

Effective Date: _____

Date of Hire: _____

❒ Annual Open Enrollment
❒ New Hire
❒ COBRA

❒ Qualifying Event

if Qualifying Event, please select:
❒ Marriage ❒ Divorce/Legal Separation
❒ Birth or Adoption ❒ Loss of coverage
❒ Other-
_____
↳**Date of Event**: _____

C) BENEFIT ELECTIONS **Note: If you are waiving coverage, flip over and complete Sections E & G.**

MEDICAL & VISION	DENTAL
❒ **Kaiser OR $2500 Medical, Rx + Vision** Group# 496, Bill Group AK	❒ **MetLife Dental Plan** Group# 05712114
PacificSource $2500 Medical Plan + VSP Vision ❒ **Base –** (PATH) – Pathfinder Network ❒ **Buy-up** – (VOY) - Voyager Network Group# G0032150 / VSP Group# 12077601, Division 1025	❒ **Willamette Dental Plan** Group# Z600X

D) FAMILY MEMBER ENROLLMENT INFORMATION

Complete this section if you are electing Medical/Dental/Vision coverage for yourself and/or any dependents.
If you wish to cover family members for Medical/Dental/Vision coverage, you must enroll them in the same coverage you elect for yourself, e.g. all family members in the Medical plan.

Last Name, First, MI	SSN	Date of Birth (MM/DD/YYYY)	Gender	Coverage Enrolled
Spouse (❒ if Domestic Partner)			❒ Male ❒ Female	❒ Medical/Vision ❒ Dental
Child (❒ if Domestic Partner's Child)			❒ Male ❒ Female	❒ Medical/Vision ❒ Dental
Child (❒ if Domestic Partner's Child)			❒ Male ❒ Female	❒ Medical/Vision ❒ Dental
Child (❒ if Domestic Partner's Child)			❒ Male ❒ Female	❒ Medical/Vision ❒ Dental

Note: 1) If you are enrolling a Domestic Partner and/or any of your Domestic Partner's Child(ren), a separate affidavit may be required by your employer. Please, see HR for more information. 2) If you wish to enroll more than three children, please attach a separate sheet of paper with personal information and coverage elections. Please, also specify any dependents living outside of Oregon who would like to enroll in these plans.

Is the coverage of any dependent required by a child support order? ❒ No ❒ Yes (if yes, please attach a copy of the court order)

E) BASIC LIFE AND AD&D INSURANCE

Group Life and AD&D coverage is provided to all eligible employees at **no additional cost**. Provide Beneficiary Information below:

Primary Beneficiary Last Name, First , MI	Relationship	SSN (optional)
Street Address City	State & Zip	Percentage (must equal 100%)
Contingent Beneficiary Last Name, First , MI	Relationship	SSN (optional)
Street Address City	State & Zip	Percentage (must equal 100%)

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate additional Primary or Contingent Beneficiaries, please attach a separate sheet of paper.

F) ENROLLMENT CONFIRMATION

I have read, understood, and agreed to the terms and conditions stated on this enrollment form. I hereby acknowledge that I and my dependents, *if applicable*, have been given the opportunity to participate in the group insurance plan provided by my employer. For the insurers or membership programs that I have chosen, I permit the proper reductions/deductions, *if any*, from my earnings as my part of the cost of this insurance or membership programs.

PacificSource Subscriber Acknowledgement: I acknowledge and understand that PacificSource Health Plans may request or disclose health information about me or my dependents (persons listed for benefit coverage on this enrollment form) for the purpose of facilitating healthcare treatment, payment for healthcare services, or for business operations necessary to administer healthcare benefits; or as required by law. This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for this information. For more information about such uses and disclosures please refer to our Privacy Policy that is available at PacificSource.com.

Premium Only Plan. By signing below, I agree to have my salary reduced on a pre-tax basis to pay the premiums offered by my employer for medical, dental, vision and/or other qualified benefits under Section 125 for myself and my eligible family members. This election will remain in effect for successive Plan Years or until I no longer contribute to these benefits due to an eligible change in status, unless I notify my employer in writing. If my domestic partner and/or domestic partner's child(ren) do not qualify as a Section 152 Tax Dependent, I understand that premiums associated with their coverage will be paid after-tax dollars and the fair market value of any employer contributions and/or HRA reimbursements made on behalf of them would be imputed as income.

It may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Signature: _____ **Date:** _____

Print Name: _____

G) WAIVER of COVERAGE: ❒ Medical/Vision ❒ Dental

I have read, understood, and decline my employer's offer of coverage for myself and/or my dependents. By waiving my employer's offer of affordable coverage for the 2018-2019 plan year, I understand I will not be eligible to re-enroll until the open enrollment period for the 2019-2020 plan year. My waiver of coverage is FINAL for the 2018-2019 plan year, unless I experience a qualifying change in status including: a legal marriage, a divorce or legal separation, the birth or adoption of an eligible child, the death of a spouse or covered child, a change in work status for myself, my spouse or a child that affects my eligibility for benefits; if I experience one of these qualifying events, I will notify HR within 30 days and complete the necessary enrollment forms.

Reason for Waiving:

❒ **Group Coverage** ❒ **Individual Coverage** ❒ **Marketplace/Public Exchange** ❒ **No Other Coverage**

❒ **Other:** _____

Signature: _____ **Date:** _____

Print Name: _____

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