



# ENROLLMENT APPLICATION AND CHANGE OF INFORMATION FORM

- New
- Change

School District Name: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Employee Soc Sec #: \_\_\_\_\_ Employee Name: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_ Male  Female  Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Employee Address: \_\_\_\_\_

<b>Classification:</b>	<input type="checkbox"/> Admin Conf	<input type="checkbox"/> Licensed	<input type="checkbox"/> Classified	<input type="checkbox"/> Other _____			
<b>Coverage Status::</b>	<input type="checkbox"/> Retired	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Other _____			
<b>Qualifying Event:</b>	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Birth Adopt	<input type="checkbox"/> Loss of Primary Insurance	<input type="checkbox"/> Qualified Domestic Partner

**To change address:** complete address section above ↑; **to add Dependent:** complete dependent section below ↓ (list reason); **to drop Dependent(s):** list dependent(s) being terminated in section below ↓ (list reason); **to change name:** list former and new names below ↓

Former Name \_\_\_\_\_ New Name \_\_\_\_\_

\*SP (Spouse) S (Son) D (Daughter) DP (Domestic Partner) Other (Specify Relationship)

Add + Drop -	List All Family Members To Be Covered:			Social Security Number	* (See Above) Relation	Sex M/F	Date of Birth		
	Dependent(s) Full Name						Month	Day	Year

➤Specify the relationship to you of any person listed above whose last name differs from yours: \_\_\_\_\_

➤List Reason for add or drop: \_\_\_\_\_

To add/drop additional dependents, use additional sheet, do not use back of form.

Check box(es) to designate desired coverage(s) <b>Specify Plan Where Indicated:</b>	EE Only	EE + One	EE + Family
<input type="checkbox"/> Medical <b>Plan Name:</b>			
<input type="checkbox"/> Kaiser <b>Group # 1614</b> __ __ __ __ (Office Use Only)			
<input type="checkbox"/> Dental ODS <input type="checkbox"/> Willamette Dental <input type="checkbox"/> Kaiser Dental			
<input type="checkbox"/> Vision <b>Plan Name:</b>			
<input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Short-Term Disability			
<b>Life Insurance:</b> <input type="checkbox"/> Negotiated Life (Group Coverage)			
<b>Life Insurance:</b> <input type="checkbox"/> Voluntary Life (Individual Coverage - UnumProvident Application Form Required)			

**Life Insurance Beneficiaries.** Designate percentage for each beneficiary. This signed, dated form supersedes any previous Enrollment or Change of Status Form.

	Name (Please Print)	Relation	Percent
<b>Beneficiary</b>			%
<b>Beneficiary</b>			%
<b>Beneficiary</b>			%

*Please read, sign and date:* **Form must be signed and dated to activate insurancelchanges.** **Total must equal 100%**

**I certify under penalty of perjury under the laws of the State of Oregon that the foregoing is true and accurate to the best of my knowledge.**

I acknowledge and understand my health plan may request or disclose health information about me or my dependents 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 include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, 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 503 620-3822.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_