OSU Graduate Assistant
Health Insurance
ENROLLMENT APPLICATION

PacificSource HEALTH PLANS

PO Box 7068 • Springfield, OR 97475
541.684.5583 or 866.999.5583
Membership Fax 541.225.3642
Marketing Fax 541.225-3645
PacificSource.com

Group Policy No.	Subgroup No.	Class No, Classification, or Plan Design	
G0021007	☐P001 – Active ☐P002 – COBRA	☐1001 – Graduate Assistant ☐1003 – Clinical Fellow/Post Doctoral ☐1005 – Summer	☐1002 – Graduate Fellow ☐1004 – Post Doctoral Fellow ☐9001 – COBRA

Enrollment Information

Employer/Group Name		Coverage Begin Date
OSU Graduate Assistant Health Insurance		month_____ day_____ year_____
Assistant/Begin Date	Asst. FTE/Fellow/Post Doc	Department Name / Status
		☐Active ☐COBRA ☐Other

Employee Information

Employee Last Name	First Name	M.I.	Student Identification No.

Mailing Address	City	State	ZIP code

Home Phone No.	Email Address	Work Phone No.

Gender ☐Male ☐ Female

Marital Status ☐Married ☐Single ☐Domestic Partner–If checked, are you registered? ☐Yes ☐No If yes, State:_____

Are you an active employee? ☐Yes ☐No If yes, complete Section 2A. If no, complete Section 2B.

Section 2A – Type of New Enrollment
I am ☐New Employee ☐Adding dependent spouse, partner, or child
Date of qualifying event:_____ *Attach proof of event*
☐New Hire ☐Marriage ☐Domestic Registration or Affidavit ☐Birth
☐Adoption ☐Court Order ☐Involuntary loss of other group coverage
☐Late Enrollment or Open Enrollment *(see disclosure for information)*

Section 2B – Continuation of Coverage
I am eligible for ☐COBRA ☐State Continuation
Date of qualifying event:_____
☐Termination of employment or reduced hours
☐Divorce or legal separation ☐Death of employee
☐Dependent no longer meets eligibility

Employee and Family Members You Wish to Enroll

[1] Ethnicity/Race Code: **AIAN**-American Indian/Alaska Native, **A**-Asian, **B**-Black/African American, **H-**Hispanic/Latino, **N**-Native Hawaiian/Other Pacific Islander, **W**-White/Caucasian

Name	*Gender*	*Birth Date*	*Social Security Number–**Required** Section 111 of Public Law 110-173*	*Ethnicity/Race[1]*	*Coverage*
Employee					☐Medical ☐Dental
Spouse or Domestic Partner					☐Medical ☐Dental
Dependent Child					☐Medical ☐Dental
Dependent Child					☐Medical ☐Dental
Dependent Child					☐Medical ☐Dental
Dependent Child					☐Medical ☐Dental
Dependent Child					☐Medical ☐Dental

If you or your spouse/domestic partner are a **court-ordered guardian** of any dependent listed above, identify and provide proof:
Name(s):_____ ☐Grandchild ☐Niece/Nephew ☐Sibling ☐Foster ☐Other:_____

Primary language spoken in household: ☐English ☐Español ☐Other:_____

Para asistirle en español, por favor llame al número (800) 624-6052, ext. 1009, de Lunes a Viernes, 7:00 a.m. hasta 5:00 p.m

Other Coverage

Current or Prior Coverage Information – Do you or any person listed on this application have or have had health insurance in the last 24 months? ☐No ☐Yes If yes, complete the following **and** attach proof with dates of coverage.

Name(s)	Insurance Carrier	Date of coverage	Will Coverage Continue?	Type of Coverage
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐Yes ☐No	☐Dental ☐Medical ☐Vision
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐Yes ☐No	☐Dental ☐Medical ☐Vision

Married or Partner – Is your spouse or domestic partner employed? ☐Yes ☐No If yes, self employed? ☐Yes ☐No

Medicare – If you or any person on this application has Medicare, indicate coverage: ☐Part A ☐Part B ☐Part D

Name	Original Effective Date	Medicare No. (include alpha prefix)	Reason for Medicare Entitlement
			☐Age ☐ESRD ☐Disability ☐Dual Entitlement

Child Custody Information

If you are enrolling children of a previous relationship, you must complete this section. Also, list court ordered coverage in Other Coverage section above. Oregon law requires PacificSource to provide plan information to the custodial parent.

Child's Name	Whose Child	Joint Custody	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone No.	Name Responsible for Insurance (court order)
	☐Yours ☐Spouse	☐Yes ☐No				
	☐Yours ☐Spouse	☐Yes ☐No				

Electronic Communications

By checking the following box, you affirmatively consent to the following: (1) to submit your application for enrollment on a PacificSource Health Plans ("PacificSource") group policy filed electronically over a secured internet connection, (2) your electronic submission has the same force and effect as if you had submitted a paper application to PacificSource with your signature, (3) to receive secured electronic communications from PacificSource regarding your application and/or enrollment status, and (4) to keep PacificSource informed of your current e-mail address that it may use to correspond with you.

You may, at any time, opt out of these electronic communications or request a free paper copy of your application and/or enrollment information by contacting our Membership Department at membership@pacificsource.com, or toll-free at 866.999.5583. Electronic communications are offered as a convenience only and your decision not to receive electronic communications will not affect your enrollment and there is no charge associated with switching to paper. PacificSource highly recommends you keep a copy of your application and any associated materials.

In order to complete the application electronically, you must have a personal computer or other device capable of accessing the internet and the ability to view and revise Portable Document Format (PDF) files. You can obtain a free copy at http://get.adobe.com/reader/. PacificSource takes the security of electronic information and communications seriously. If you have any questions about our encryption, technical hardware or software, or our security policies and procedures, please contact us at membership@pacificsource.com.

I agree: ☐Yes ☐No Email Address:_____

Acknowledgement and Declaration

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating healthcare treatment, payment, or for business operations necessary to administer healthcare 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 healthcare 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 or dental 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 psychotherapy notes. A separate authorization will be used for this information.*

I affirm that the answers given in this application are complete and correct. I, the applicant, authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group contract.

Employee Signature:_____ **Date:**_____

OSU Graduate Assistant
Health Insurance

ENROLLMENT APPLICATION

PacificSource HEALTH PLANS

Keep a copy for your records.

Employee Eligibility

You are eligible if you are a graduate teaching fellow employed as such by the Oregon State. You are also eligible if you are on an approved leave of absence under the Medical and Family Leave Act of 1993. Your initial eligible for participation on the group health plan is contingent upon your appointment of a 0.20 FTE for the term in which you are enrolling.

You must file an application for yourself and any dependents you want insured no later than 31 days from the date you receive your graduate teaching appointment. A new application must be submitted if you have a lapse in coverage.

Instructions

This enrollment application contains two parts: the Disclosures Section and the Enrollment Information Section.

- **Read the Disclosures Section carefully** to help you understand certain requirements of your employer's health plan.
- **Detach the Disclosures page** and save it for future reference.
- **Complete the Enrollment Information Section.** Be sure to answer everything in this application that applies to you.
- **Sign and date the form.**
- **Return the Enrollment Information page to your plan administrator**.

Disclosures Section

Employee and Family Members You Wish to Enroll

Dependents – Dependents of a covered employee who meet one of the following requirements may also be eligible for enrollment if this plan covers. Please contact your employer to determine if dependents are eligible to enroll under this plan.

- Your legal spouse or qualified domestic partner.
- Your, your spouse's, or your qualified domestic partner's dependent children or foster child under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your spouse's, or your qualified domestic partner's unmarried dependent children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage.
- Your sibling, niece, nephew, or grandchild under age 19 who is unmarried, or not in a qualified domestic partnership, who is related to you by blood, marriage, or qualified domestic partnership AND for whom you are the court appointed legal custodian or guardian with the expectation that the family member will live in your household for at least a year.
- A child placed for adoption with you, your spouse, or qualified domestic partner. Placed for adoption means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption or placement for adoption. Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

No family or household members other than those listed above are eligible to enroll under your coverage.

Special Enrollment Rights

Coverage begins on the first day of the term the student receives at least a 0.20 FTE appointment if this completed enrollment form is received by the OSU Student Health Insurance Office, 110 Plageman Building, within 31 days of the appointment. For purpose of the group health policy, the first day of each term is defined as follows.

Fall: October 1 Winter: January 1 Spring: April 1 Summer: July 1

In the event of a late assistantship, the effective date will instead be determined by the date the offer was made. A graduate assistantship with an effective date prior to the 16th of a month will be effective the first of that month. A graduate assistantship with an effective date on or after the 16th of the month will be effective on the first day of the following month.

The PacificSource group health plan offered by your employer contains provisions that, in certain situations, may allow you or your family members to enroll in the plan later if you decline enrollment when you are first eligible. These special enrollment rights affect both you and your eligible family members.

Enrollment is optional for dependents. In addition, employees with other equivalent or better group health coverage may waive the PacificSource group coverage (see Waiving Health Coverage below). You may enroll in the plan later if you qualify under Rule #1 or Rule #2 below. Employees must have also submitted a waiver form to PacificSource during your initial enrollment period or at the time you disenrolled in the group plan to qualify under Rule #1 or Rule #2.

- *Special Enrollment Rule #1* – If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members may enroll in the plan later if the other coverage ends involuntarily. You must request enrollment within 31-days after the other coverage ends (or within 60-days after the other coverage ends if it is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.
- *Special Enrollment Rule #2* – If you acquire new dependents because of marriage, newly qualified domestic partnership, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired dependents at that time. You must request enrollment within 31-days after the qualifying event. In the case of marriage or domestic partnership, coverage begins on the first day of the month after the event. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.

- *Special Enrollment Rule #3* – If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and/or your dependents at that time. You must request enrollment within 60 days of the date of eligibility for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollee – *If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the plan's next designated open enrollment period.* A 'late enrollee' is an otherwise eligible employee or dependent who does not qualify for a special enrollment period explained above, and who: did not enroll during the initial enrollment period; or enrolled during the initial enrollment period but discontinued coverage later.

Dental Employer Groups – An employee or dependent that did not enroll within the 31-day initial enrollment period may enroll later on the policy's anniversary date. An employee or dependent that enrolled and later discontinued coverage may re-enroll in the plan on an anniversary date of the policy following a 24-month waiting period from the date coverage was discontinued.

Waiving Coverage – If your employer has an agreement with PacificSource allowing employees to waive group coverage, you and your family members may decline coverage when you are first eligible. To decline coverage, complete a *Waiver of Coverage form* instead of this form.

For more information on your plan's special enrollment provisions, please refer to your Member Benefit Handbook or contact the PacificSource Membership Department at 541.684.5583 or 866.999.5583.

PacificSource HEALTH PLANS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

FROM: OSU Graduate Assistant Health Insurance (the employer)

ADDRESS: 201 Plageman Building, Rm 110, Corvallis, OR 97331 PHONE: (541) 737-7568

TO: Employee

What This Notice is About: You are receiving this notice because you recently became covered under the company's group health plan, hereafter referred to as "the Plan." This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage.

This notice explains COBRA continuation coverage in general, when coverage may become available to you and your family, and what you need to do to protect your right to receive it. This notice gives only a summary of your COBRA continuation rights. For more information about your rights and obligations under the Plan and under federal law, you should review your Member Benefit Handbook or Summary Plan Description, or contact the Plan Administrator.

COBRA Continuation Coverage: COBRA continuation coverage is a continuation of the Plan's coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are responsible for payment of COBRA continuation coverage premium.

Qualifying Events: If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan due to one of the following qualifying events:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan due to one of the following qualifying events:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced from your spouse. If an employee cancels coverage for his or her spouse in anticipation of a divorce and a divorce later occurs, then the divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the plan administrator within 60 days after the divorce and can establish that the employee canceled the coverage earlier in anticipation of the divorce, then COBRA coverage may be available for the period after the divorce.

Your dependent children will become qualified beneficiaries if they will lose their coverage under the Plan due to one of the following qualifying events:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced; or
(6) The child stops being eligible for coverage under the Plan as a "dependent child."

To Retirees Covered Under the Plan (when applicable): Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If the employer sponsoring the Plan files a proceeding in bankruptcy, and that bankruptcy causes retired employees covered by the Plan to lose their coverage, then those retired employees are qualified beneficiaries. Retired employees' spouses and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Employer Notification Requirements: The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified in a timely manner that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy by the employer (for covered retirees only), or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

Your Notification Requirements: For other qualifying events (divorce or a dependent child's losing eligibility for coverage as a dependent child), *you must notify* the Plan Administrator. The Plan requires you to notify the Plan Administrator **in writing** within 60 days after either the qualifying event or the loss of coverage, whichever is later, using the procedure specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

Notification Procedures: Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or deliver your notice to the Plan Administrator. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must include the name and address of the employee covered under the Plan and the names and addresses of the qualified beneficiaries. Your notice must also name the qualifying event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Electing COBRA Continuation Coverage: Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage within the allotted time, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. **If you, your spouse, or your dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.**

Coverage Periods: COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension: If you or anyone in your family covered under the Plan is determined by Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months total. You must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within 60 days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension: If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum period of coverage of 36 months total. This extension is available to the spouse and dependent children if the former employee dies or gets divorced. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure the Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. In regards to a second qualifying event, you must follow the notification procedures outlined above. In case of divorce, your notice must include a copy of the divorce decree. If notice is not provided in writing to the Plan Administrator within the required 60-day period, then there will be no extension of COBRA continuation coverage due to a second qualifying event.

Medicare Extension for Spouse and Dependent Children: If a termination of employment or a reduction of hours is the qualifying event and it occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end three years from the date the employee became entitled to Medicare.

Newborn and Adopted Children: A child born to, adopted by, or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan through special enrollment and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

Alternative Recipient under a Qualified Medical Child Support Order (QMCSO): A child who is receiving benefits under the Plan pursuant to a QMCSO received by the Plan Administrator during the covered employee's period of employment is entitled to the same rights under COBRA as a dependent child of the covered employee, regardless of whether the child would otherwise be considered a dependent.

If You Have Questions: If you have questions about your COBRA continuation coverage, you should contact your Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes: In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Administrator Name: Rachel Forslund Phone: (541) 737-7568

Address: 201 Plageman Building, Rm 110, Corvallis, OR 97331

COBRA Administrator Name (if different from Plan Administrator): PacificSource Administrators - COBRA

Address: PO Box 71096, Springfield, OR 97475 Phone: (877) 355-2760