

INSTRUCTIONS FOR APPLYING FOR THE PERS HEALTH INSURANCE PROGRAM

Review the medical plan benefits and service areas to determine which insurance plan best suits your needs. See your PERS Health Insurance Program Member Handbook and Benefit Guide Table of Contents to locate these sections.

Review the dental plan benefits and determine if you desire dental insurance. Kaiser Permanente and ODS dental plans are available with ANY of the medical plans.

NOTE: Dental insurance can generally be selected only when first enrolling in the PERS Health Insurance Program.

CHECKLIST

Please complete pages 1-4 of the Enrollment Request Form. Page 5 is optional.

Section

- (A) Did you complete the Requested Enrollment Date: This is the date you want your PERS Health Insurance Program coverage to start. Your signature date **must** be before this effective date!
- Did you request and complete a termination form if you are changing or cancelling a plan? Available at pershealth.com
- (A) Did you complete the retiree information?
- (A) Did you list your family members that you want to enroll?
- (A) Did you complete the reason for enrollment in the PERS Health Insurance Program? **If the reason is Group Coverage Ending, you must include proof of coverage such as a Certificate of Coverage for prior 24-months.**
- (B) Did you complete the Medicare Information? You must complete for each enrolling member with Medicare and attach a copy of your Medicare Cards to the Enrollment Form.
- (C) Did you check the box to choose your medical plan?
- (D) Do you wish to enroll with dental coverage? If yes, did you choose ONE Dental plan for all enrollees?
- (D) If you enrolled in a dental plan, did you answer the continuous dental coverage question for each enrollee? If you answered "Yes" did you include the name of the dental plan?
- (E) Did you complete the "Payment Option" section? If you chose EFT, did you attach a voided check?
- (F) Did you answer the Important Questions on page 3? You **must** answer for each enrolling member.
- (F) Did you answer the coordination of benefits questions number 4 and 5?
- (G) Did you read the Release of Information on page 3?
- (H) Did you read the Lock-In and the important statements on page 3?
- (I) Did you read the "I agree to the following" section?
- (J) Did you and your spouse (if enrolling) sign and date the Enrollment Form? Did you check to see if the Requested Enrollment Date is after your signature date?
- (K) Did you complete the Authorization to Disclose Protected Health Information form on page 5? (*Optional*)

Keep the yellow copy for your records and mail the white copy and any attachments to:

**PERS HEALTH INSURANCE PROGRAM
PO BOX 40187
PORTLAND, OR 97240-0187**

The Portland area FAX is: (503)-765-3452 or toll free FAX: 1-(888)-393-2943

In the Portland area call: (503) 224-7377 or toll free at: 1-(800)-768-7377

ENROLLMENT REQUEST FORM



P.O. Box 40187, Portland, Oregon 97240-0187
(503) 224-7377 or 1-800-768-7377

A. INFORMATION ABOUT YOU

Your Requested Enrollment Date: _____	OFFICE USE ONLY	Member ID # _____	SEP (type): _____	Not Eligible: _____	Plan #: _____
		Effective Date of Coverage: _____	PBP _____		Premiums: _____
		ICEP/IEP: _____	OEP: _____	AEP: _____	Tran. Code: _____
					Group #: _____

Retiree Last Name _____ First _____ MI _____	Social Security No. _____	Date of Birth _____	Gender M / F _____	Medicare eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Last PERS Employer: _____ Date of Retirement: _____ Years of Service: _____

➔ **Individuals Enrolling** Retiree Retiree & Family Spouse Only Surviving Spouse Dependent

Spouse Last Name _____ First _____ MI _____	Social Security No. _____	Date of Birth _____	Gender M / F _____	Medicare Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Child Last Name _____ First _____ MI _____	Social Security No. _____	Date of Birth _____	Gender M / F _____	Medicare Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If other dependents, please attach a separate sheet.

Reason for this Enrollment (Check all that apply) New PERS Retiree New Dependent Other: _____

Plan Change: _____ Medicare Eligible Moving out of the Area Snowbird Option

Current Plan: _____ Group Coverage Ending. Insurance Company Name: _____ Date: _____

New Plan: _____ Rx Health ID#: _____ Phone Number: _____

Permanent Resident Address (Not a P.O. Box) Street: _____ Apt# _____

City: _____ State: _____ ZIP Code: _____ County: _____

Phone Number: _____ E-mail Address: _____

Mailing Address if Different: Street or P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

B. MEDICARE INFORMATION

If you are enrolling in a Medicare plan, please take out your Medicare Card to complete this section. Fill in the blanks to match your Red, White and Blue Medicare card and **attach a copy of your Medicare Card** or your letter from the Social Security Administration or Railroad Retirement Board. **YOU MUST HAVE Medicare Part A and Part B to join a PERS Health Insurance Program Medicare Plan.**

Retiree	
SAMPLE ONLY	
Name: _____	
Medicare Claim Number _____	Sex _____
Is Entitled To _____	Effective Date _____
HOSPITAL (Part A) _____	
MEDICAL (Part B) _____	

Spouse/Dependent	
SAMPLE ONLY	
Name: _____	
Medicare Claim Number _____	Sex _____
Is Entitled To _____	Effective Date _____
HOSPITAL (Part A) _____	
MEDICAL (Part B) _____	

C. CHOOSE YOUR MEDICAL PLAN (Medicare and non-Medicare family members must enroll with the same Health Insurance Plan.)

Clear One Health Plans	Kaiser Foundation Health Plan of the Northwest	ODS Health Plan, Inc	Providence Health Plans
MEDICARE PLANS			
<input type="checkbox"/> PERS Traditional Plan* with ODS Advantage Rx (PDP)**	<input type="checkbox"/> Kaiser Permanente Senior Advantage* with Kaiser Rx**	<input type="checkbox"/> ODS Advantage PPORX* <input type="checkbox"/> ODS Medicare Supplement with ODS Advantage Rx (PDP)**	<input type="checkbox"/> Providence Medicare Extra Group (HMO)†* <input type="checkbox"/> Providence Medicare Choice Group (HMOPOS)†* ‡ with ODS Advantage Rx (PDP)**
NON-MEDICARE PLANS			
<input type="checkbox"/> Clear One Non-Medicare with ODS RX	<input type="checkbox"/> Kaiser Permanente Non-Medicare with Kaiser RX	<input type="checkbox"/> ODS Non-Medicare PPO with ODS RX	<input type="checkbox"/> Providence Non-Medicare with ODS RX

* A Health Plan with a Medicare contract. ** A Medicare approved Part D Sponsor.

If available, would you prefer your health plan information in a language other than English or in another format : Audio tapes CD-ROM Spanish: Providence 1-800-603-2340
Kaiser Permanente 1-800-813-2000

D. CHOOSE YOUR DENTAL PLAN (Select only one plan.)

Kaiser Permanente Dental ODS Dental I do not want dental coverage
Have you and/or your dependents had Continuous Dental Coverage for the last 24-Months?
Retiree YES NO Spouse YES NO Dependents YES NO Name of Dental Plan: _____

Dental can only be selected when first eligible for PERS Health Insurance Program

E. PAYMENT OPTIONS (Select one payment option)

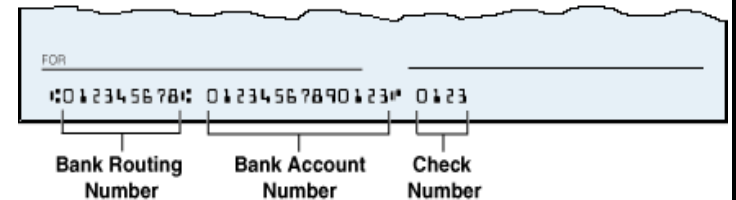
Option 1: **PENSION DEDUCTION**

The health insurance premium is automatically deducted from the PERS retiree's monthly pension check. The retiree's pension check must be large enough to cover the entire monthly premium. By selecting this option and signing below, I hereby authorize the PERS Health Insurance Program to deduct my monthly premium for medical and/or dental insurance from my monthly PERS pension check. I also understand that it may take up to 90 days for the premiums to begin deducting and that I will be invoiced until the deduction begins in order for my health insurance to be kept current.

Option 2: **ELECTRONIC FUNDS TRANSFER (EFT)** (Please attach a voided check.)

The health insurance premium is electronically deducted from your bank checking account at the beginning of each month. It may take up to 90 days to begin electronic deductions. You will receive and pay via a monthly invoice until it begins, so your health insurance is kept current.

Bank Name: _____
Routing No. _____ **Account No.** _____



Option 3: **MONTHLY PREMIUM NOTICE (Direct Pay and Premium Notice)**

A Premium Notice is mailed to you mid-month for the health insurance premium due the first of the following month.

The selected payment option will remain in effect until the PERS Health Insurance Program has received written notification from me of its termination.

F. PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

Medicare Only	1. Are you enrolled in your State Medicaid program? Retiree <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse/Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide your Medicaid number _____
	2. Do you have End Stage Renal Disease (ESRD) ? Retiree <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse/Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered YES to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.
Medicare and Non-Medicare	3. Are you a resident of a long term care facility, such as a nursing home? Retiree <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse/Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, name of the institution: _____ Phone Number: _____ Address: _____ City: _____ State: _____ Zip: _____ Date of Admission: ____ / ____ / ____
	4. Are you actively working for an employer with 20 or more employees who provides employee group health insurance coverage for you? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, are you retired? <input type="checkbox"/> Yes Retirement Date: _____ Is your spouse actively working for an employer with 20 or more employees who provides employee group health insurance coverage for you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
	5. Some individuals may have other health or drug coverage, including other private insurance, TRICARE, Federal Employees Health Benefits Program, VA benefits, Worker's Compensation or state pharmaceutical assistance programs. Will you (or your enrolling spouse/dependent) have other health or prescription drug coverage in addition to: <i>PERS Prescription Drug plan</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>PERS health plan</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list your other coverage and your identification (ID) number(s) for this coverage:
Retiree	Name of other coverage: _____ ID# for this coverage: _____ Group # for this coverage: _____ <input type="checkbox"/> Rx <input type="checkbox"/> Health
Spouse / Depend.	Name of other coverage: _____ ID# for this coverage: _____ Group # for this coverage: _____ <input type="checkbox"/> Rx <input type="checkbox"/> Health
Retiree: Primary Care Provider (First & Last Name) _____ Spouse/Dependent: Primary Care Provider (First & Last Name) _____	
Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

G. RELEASE OF INFORMATION

By joining this Medicare or the Non-Medicare healthplan, I acknowledge that the Medicare or Non-Medicare health plan will release my information to Medicare or other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the PERS Health Insurance Program will release my eligibility and healthcare information, including my prescription drug event data to Medicare or other plans, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

H. LOCK-IN

I understand that beginning on the date my Clear One Health Plan Medicare Advantage, Kaiser Permanente Senior Advantage, Kaiser Permanente Non-Medicare or Providence Medicare Extra plan begins, members will receive all of their health care from, or have authorized their plan's contracted providers, with the exception of emergency or urgently needed services or out-of-area dialysis services. (Refer to your health plan to determine coverage for emergency and urgently needed services, out of area dialysis services, and travel benefits.)

I understand that the ODS Advantage PPO, ODS Medicare Supplement, ODS Non-Medicare PPO, Clear One Non-Medicare, Providence Medicare Choice (HMOPOS) or the Providence Non-Medicare plan allows me to see any Medicare provider of my choice. (Excess charges may apply when using Medicare providers outside of the network.)

I. I AGREE TO THE FOLLOWING

Medicare Only

By completing this enrollment application, I agree to the following:

1. I will keep my Medicare Part A and Part B coverage.
2. I can only be in one Medicare Advantage and/or one Part D prescription drug plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage or another Part D prescription drug plan.
3. It is my responsibility to inform the PERS Health Insurance Program of any other health or prescription drug coverage that I have or may get in the future.
4. I will read the Evidence of Coverage or member handbook for my plan when I receive it to know which rules I must follow in order to receive coverage. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border (Exception - the PERS Health Insurance Program plans offer Emergency and Urgent Care worldwide).

Medicare and Non-Medicare

By completing this enrollment application, I agree to the following:

1. Enrollment in this plan is generally for the entire calendar year.
2. I may leave this plan only at certain times of the year, or under certain circumstances, by sending a request to the PERS Health Insurance Program.
3. If I move out of my plan's service area, I will notify PERS Health Insurance Program so I can disenroll and find a new plan in my new service area.
4. I have the right to appeal my plan decisions about payment or services.
5. I understand that if I currently have health insurance coverage from another employer or union plan, joining a PERS plan could affect my current employer or union health benefits. If I have health coverage from another employer or union plan, joining PERS may change how my current coverage works. (If you have questions, visit their web site, or contact the office listed in their communications. If there is no information, you may wish to contact your benefits administrator or the office that answers questions about your coverage.

J. SIGN HERE

Signature Required By All Enrollees (Retiree and/or Spouse)

I understand that my signature (or the signature of the person authorized to act on behalf of the enrollee under the laws of the state where the enrollee resides) on this application certifies that I have read and understand the contents of this application. Medicare members agree to keep their Medicare Part A and Part B coverage current and to inform PERS Health Insurance Program of any other health or prescription drug coverage that they have or may get in the future. Medicare members agree that they can only have one Medicare prescription drug plan at a time.

Retiree Signature _____

Today's Date _____

Spouse Signature _____

Today's Date _____

If signed by an authorized individual (as described above) this signature certifies that:

- 1) This person is a parent or guardian for dependent child(ren);
- 2) This person is authorized under state law to complete this enrollment; and
- 3) Documentation of this authority is available upon request by the Insurance Plan, PERS Health Insurance Program or Medicare. Please complete the following information and attach proof of Legal Guardian, Durable Power of Attorney for Health Care (DPAHC), or proof of authorization by state law.

Name: _____ **Phone Number:** _____

Address: _____

Form Completed by (Name): _____ **Relationship to Enrollee:** _____ **Date:** _____

K. AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (Optional)

Purpose: This authorization allows the PERS Health Insurance Program and/or your health plan to discuss your retirement date and years of PERS pension service, health plan enrollment, date of enrollment, disenrollment with your health plan, billing and premium information with the individual identified below.

Each person enrolled who wants to share this information must complete a separate authorization. Additional authorization forms may be found on the PERS Health Insurance Program website (www.pershealth.com).

I authorize: Representatives of The PERS Health Insurance Program and health plan:

- ODS Health Plan, Inc. Kaiser Permanente
- Clear One Health Plans Request Providence-specific PHI form

to obtain and disclose my Protected Health Information to:

Name: _____ Relationship: _____

Address: _____ Phone #: _____

For: The information disclosed may include any of the following elements: Verification of retirement date and years of PERS pension service, Health Plan enrolled in, Date of enrollment/dis-enrollment with health plan, Billing and Premium information. Information obtained or disclosed with this authorization for the purpose defined above will be limited to the minimum information to achieve the purpose.

I have the right to revoke this Authorization in writing at any time. If I revoke this Authorization, the information described above will no longer be disclosed for the reasons covered by this written Authorization except to the extent action has been taken with reliance on this Authorization. Any uses or disclosures already made with my permission cannot be taken back. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure and no longer protected under federal law.

This authorization shall be in force and in effect until the following date OR event:

Date: (Not to exceed 24 months) _____

Describe Event: _____

I have reviewed and I understand this Authorization:

PERS Health Insurance Program Member: Name _____ SSN# _____

Signature: _____ Date: _____

- OR -

PERS Health Insurance Program Member's Representative: Name _____

Address: _____ Phone #: _____

Signature: _____ Date: _____

Relationship to member: ___ Parent ___ Legal Guardian* ___ Hold Power of Attorney*

*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney

All fields must be completed for this authorization to be valid.

Member must keep the yellow copy of the completed form.

To revoke this Authorization, please send a written statement to:

Attention Privacy Office • PO BOX 40187 • Portland, OR 97240-0187