

# 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
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- (A) Did you complete your Requested Enrollment Date? This is the date you want your PERS Health Insurance Program coverage to start.
- (A) Did you complete the retiree information?
- (A) Did you only list family members that you want enrolled? (Please include dependents already enrolled.)
- (A) Did you complete the Reason for this Enrollment in the PERS Health Insurance Program? **If the reason is "Group Coverage Ending", proof of current coverage is required** (ex. Certificate of Coverage for prior 24-months).
- (A) Did you request and complete a termination form if you are changing a plan?  Available at pershealth.com
- (B) Did you complete the Medicare Information? You must complete for each enrolling member with Medicare and attach a copy of the Medicare cards to the Enrollment Request 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/other insurance coverage 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 on page 4?
- (J) Did you and your spouse (if enrolling) sign and date the Enrollment Form? Did you check to see if your Requested Enrollment Date is **after** your signature date? Your signature date **must** be before this effective date, but not earlier than 90 days prior.
- (K) Did you wish to 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 • TTY available: 711

# ENROLLMENT REQUEST FORM



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

## A. INFORMATION ABOUT YOU

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

PERS Retiree Last Name _____	First _____	MI _____	Social Security No. _____	Date of Birth _____	Gender _____	Medicare eligible? M / F <input type="checkbox"/> Yes <input type="checkbox"/> No
Last PERS Employer: _____			Date of Retirement: _____		Years of Service: _____	
<input type="checkbox"/> <b>→ Individuals Enrolling</b> <input type="checkbox"/> Retiree <input type="checkbox"/> Retiree & Family <input type="checkbox"/> Spouse Only <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Dependent						
Spouse Last Name _____	First _____	MI _____	Social Security No. _____	Date of Birth _____	Gender _____	Medicare Eligible? M / F <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Last Name _____	First _____	MI _____	Social Security No. _____	Date of Birth _____	Gender _____	Medicare Eligible? M / F <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> If other dependents, please attach a separate sheet. <input type="checkbox"/> Spouse is a PERS retiree - Last PERS employer: _____						
<b>Reason for this Enrollment</b> (Check all that apply) <input type="checkbox"/> New PERS Retiree <input type="checkbox"/> New Dependent <input type="checkbox"/> Other: _____						
<input type="checkbox"/> Plan Change: <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Moving out of the Area <input type="checkbox"/> Snowbird Option						
Current Plan: _____ <input type="checkbox"/> Group Coverage Ending. Date: _____            Insurance Company Name: _____						
New Plan: _____ <input type="checkbox"/> Rx <input type="checkbox"/> Health            ID#: _____            Phone Number: _____						
<b>Permanent Resident Address</b> (Not a P.O. Box) Street: _____ Apt# _____						
City: _____ State: _____ ZIP Code: _____ County: _____						
Home Phone Number: _____ Alternate Ph. # _____ E-mail address: _____						
<b>Mailing Address if Different:</b> 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.**

MEDICARE  HEALTH INSURANCE	
SAMPLE ONLY	
Name: _____	
Medicare Claim Number _____	Sex _____
Is Entitled to _____ Effective Date _____	
HOSPITAL (Part A) _____	
MEDICAL (Part B) _____	

MEDICARE  HEALTH INSURANCE	
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.)

Kaiser Permanente	ODS Health Plan, Inc	PacificSource	Providence Health Plans
<b>MEDICARE PLANS</b>			
<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"/> PacificSource Medicare Essentials 801 with ODS Advantage Rx (PDP)**	<input type="checkbox"/> Providence Medicare Extra Group (HMO)†* <input type="checkbox"/> Providence Medicare Choice Group (HMO-POS)†* ‡ with ODS Advantage Rx (PDP)**
<b>NON-MEDICARE PLANS</b>			
<input type="checkbox"/> Kaiser Permanente Non-Medicare with Kaiser Rx	<input type="checkbox"/> ODS Non-Medicare PPO with ODS Rx	<input type="checkbox"/> PacificSource Choice POS 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.

Please contact your Health Insurance Plan if you need information in a language other than English or in another format.

**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?

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

Retiree  YES  NO      Spouse  YES  NO      Dependents  YES  NO      Name of Dental Plan: \_\_\_\_\_

**E. PAYMENT OPTIONS** (Select one payment option)

**Option 1:**  **PENSION DEDUCTION**

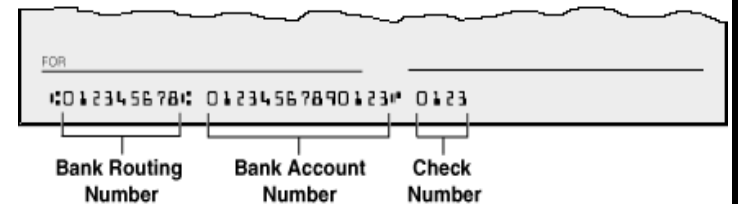
The health insurance premium is automatically deducted from the PERS retiree's monthly pension check. The retiree's pension check must be large enough to cover the entire monthly premium. By selecting this option and signing below, I hereby authorize the PERS Health Insurance Program to deduct my monthly 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  Yes  No Spouse/Dependent  Yes  No  
 If YES, please provide your Medicaid number \_\_\_\_\_
2. Do you have End Stage Renal Disease (ESRD) ? Retiree  Yes  No Spouse/Dependent  Yes  No  
 If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may contact you to obtain additional information.

Medicare and Non-Medicare

3. Are you a resident of a long term care facility, such as a nursing home? Retiree  Yes  No Spouse/Dependent  Yes  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?  
 Yes  No If No, are you retired?  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?  
 Yes  No  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: *PERS Prescription Drug plan?*  Yes  No *PERS health plan?*  Yes  No  
 If YES, please list your other coverage and your identification (ID) number(s) for this coverage:
- |   |  |
|---|--|
| <p><b>Retiree</b></p> Name of other coverage: _____<br>ID# for this coverage: _____<br>Group # for this coverage: _____ <input type="checkbox"/> Rx <input type="checkbox"/> Health | <p><b>Spouse / Depend.</b></p> Name of other coverage: _____<br>ID# for this coverage: _____<br>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?  Yes  No

Established Patient?  Yes  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 Kaiser Permanente Senior Advantage, Kaiser Permanente Non-Medicare, PacificSource Medicare Essentials 801 Plan 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, PacificSource Choice POS, Providence Medicare Choice (HMO-POS) 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**

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

Medicare Only

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 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 the 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

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.)
6. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay PERS the Part D-IRMAA.

**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
- PacificSource
- 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:**

**Date:** \_\_\_\_\_ (Not to exceed 24-months from the signature date.)

(If the date field is left blank, the authorization will expire 24-months from the signature date).

**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