

INTENT / ENROLLMENT FORM



HEALTH
INSURANCE
PROGRAM

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

Date you wish to begin coverage _____

A. Retiree Information

Retiree Last Name	First	MI	Social Security No.	Date of Birth
Residence Street Address	City	State	Zip Code	County
Mailing Address (if different)	City	State	Zip Code	County
Phone Number	Last PERS Employer	Date of Retirement	Years of Service	

B. Individuals To Be Enrolled (If other dependents, please attach a separate sheet)

Retiree Last Name	First	MI	Social Security No.	Date of Birth	Medicare Eligible?	Sex
					Yes <input type="checkbox"/> No <input type="checkbox"/>	
Spouse	First	MI	Social Security No.	Date of Birth	Medicare Eligible?	Sex
					Yes <input type="checkbox"/> No <input type="checkbox"/>	
Child	First	MI	Social Security No.	Date of Birth	Medicare Eligible?	Sex
					Yes <input type="checkbox"/> No <input type="checkbox"/>	

C. Reason For This Enrollment

Medicare Eligible
 Add New Dependent
 Snowbird Option
 Plan Change
 New Retiree
 Surviving Spouse
 Moving out of area
 Other
 Group Coverage Ending _____

Insurance Company (carrier) Name _____ ID# _____ Phone Number _____

D. Medical Plan (Select all that apply)

Clear Choice Medicare
 Kaiser Medicare
 ODS (Medicare PPO)
 Providence Medicare Choice
 ODS (MC supplement)
 Providence Medicare Extra
 Clear Choice Non-MC
 Kaiser Non-MC
 ODS Non-MC
 Providence Non-MC

Do you or your dependent(s) currently have End-Stage Renal Disease?

Retiree: Yes No Spouse: Yes No Dependent: Yes No

E. Dental Plan (Select only one plan) Dental can only be selected when first enrolling with PERS.

Kaiser Permanente Dental
 ODS Dental
 Dental coverage not desired

Have you or your dependents had Continuous Dental Coverage for the last 24 Months?

Retiree: Yes No Spouse: Yes No Dependent: Yes No

Name of Dental Plan: _____

NOTE: PLEASE READ INSTRUCTIONS ON BACK OF FORM CAREFULLY.

Signature Required By All Enrollees.

Retiree Signature _____ Date _____

Spouse Signature _____ Date _____

INSTRUCTIONS FOR APPLYING FOR THE PERS HEALTH INSURANCE PROGRAM (PHIP)

1. Review the medical plan benefits and service areas to determine which plan best suits your needs. See your PERS Health Insurance Program (PHIP) Member Handbook Table of Contents to locate these sections.
2. Review the dental plan benefits and determine if you desire dental coverage. Kaiser dental is only available if you are enrolling in the Kaiser medical plan. ODS dental is available with ANY of the medical plans.

NOTE: Dental can generally be selected only when first enrolling with PHIP.

3. Fill out the Intent / Enrollment Form completing the following information boxes:
Date you wish to begin coverage (upper left corner).
 - A. Retiree information.
 - B. Individuals to be enrolled.
 - C. Reason for enrollment in the PERS Health Insurance Program (PHIP). If the reason is Group Coverage Ending, please provide proof such as a Certificate of Coverage.
 - D. Check all applicable boxes from ONE Medical plan. All enrollees MUST answer the end-stage renal disease question. (Note: Non-MC = Non-Medicare)
 - E. If you wish to enroll with dental coverage, choose ONE Dental plan for all enrollees. Then answer the continuous dental coverage question for each enrollee. If any answers are YES, please provide the name and phone number for the dental insurance company.
 - F. Retiree and spouse (if enrolling) MUST sign and date the Intent / Enrollment Form. If you have chosen to enroll in Clear Choice, Kaiser, Providence or the ODS Medicare Advantage PPO and are enrolled in Medicare parts A & B, an enrollment application for that plan will be mailed after this form has been received at the PHIP office.
4. Make photo copies of Medicare cards for ALL Medicare eligible individuals who are applying and include the copies with this application.
5. Complete the enclosed "Payment Option Form". Select ONE option and sign in that box.
6. Mail this form and any other forms as noted above to:

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

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

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