MEDICAL ENROLLMENT/CHANGE FORM

CIS BENEFITS

Check all that apply:

☐ New Enrollment* (*new hire, newly eligible*)
☐ New Enrollment due to loss of other group coverage (*please complete Section 5, Loss of Other Group Insurance on back*)

☐ Open Enrollment* Plan Change
☐ Open Enrollment* Covered Dependent(s) Change: ☐ *Adding* ☐ *Deleting*

☐ Mid-Year Change due to the following event: Date: ____________
☐ *Marriage* ☐ *Birth* ☐ *Divorce* ☐ *Death* ☐ *Other (Please explain)* ______________________
☐ Name Change: List previous name: ____________
☐ Change of Address or Phone Number (*please provide the new information below.*)

** For **New Enrollment** and **Open Enrollment**, you are eligible for the Healthy Benefits program. To qualify, you must complete a Health Status Questionnaire. For more information, contact your employer.*

SECTION 1: EMPLOYEE INFORMATION

EMPLOYEE'S FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YY)

ADDRESS	CITY	ST	ZIP

HOME PHONE	MARITAL STATUS	GENDER
	☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED	☐ M ☐ F

EMPLOYER'S NAME	PAYCYCLE	DATE OF HIRE
Clatsop County	☐ WEEKLY ☐ BI-WEEKLY ☒ MONTHLY ☐ SEMI-MONTHLY	

RETIREMENT PLAN	EMPLOYEE'S JOB TITLE/OCCUPATION
☐ PERS TIER 1 ☐ PERS TIER 2 ☐ OPSRP ☐ OTHER Retirement Plan ☐ NO Retirement Plan	

JOB CLASSIFICATION:
☐ ADMINISTRATIVE/PROFESSIONAL/GENERAL ☐ ELECTRICAL WORKER ☐ POLICE/SHERIFF ☐ MANAGEMENT/SUPERVISORS ☐ PUBLIC WORKS/LABORER
☐ HEALTH PROFESSIONAL ☐ FIRE ☐ EMT ☐ ELECTED OFFICIAL ______________________

SECTION 2: MEDICAL COVERAGE INFORMATION

ONA (Nurses):

____ HDHP-1 with VSP-2 and Health Savings Account
____ PPO Copay Plan D with optional FSA

All other groups:

____ HDHP-4 with VSP-A and Health Savings Account
____ PPO Copay Plan H with optional Flexible Spending Account

SECTION 3: DEPENDENT INFORMATION

NAME			RELATIONSHIP	SOCIAL SECURITY NO.	BIRTHDATE	GENDER	COVERAGE
SPOUSE'S FIRST NAME *	MI	LAST		SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F	COVERAGE ☐ MEDICAL
DOMESTIC PARTNER'S FIRST NAME **	MI	LAST		SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F	COVERAGE ☐ MEDICAL
CHILD'S FIRST NAME	MI	LAST	RELATIONSHIP ☐ NATURAL ☐ STEP ☐ LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F	COVERAGE ☐ MEDICAL
CHILD'S FIRST NAME	MI	LAST	RELATIONSHIP ☐ NATURAL ☐ STEP ☐ LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F	COVERAGE ☐ MEDICAL
CHILD'S FIRST NAME	MI	LAST	RELATIONSHIP ☐ NATURAL ☐ STEP ☐ LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F	COVERAGE ☐ MEDICAL
CHILD'S FIRST NAME	MI	LAST	RELATIONSHIP ☐ NATURAL ☐ STEP ☐ LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F	COVERAGE ☐ MEDICAL

**** Must provide a copy of Marriage Certificate/License to your employer***
***** Requires completion of Certificate of Domestic Partnership***

SECTION 4: OTHER INSURANCE INFORMATION

If you or any family members listed on this application have other insurance, please complete the following:

Coverage 1

NAME OF POLICYHOLDER WITH OTHER COVERAGE	RELATIONSHIP	NAME OF INSURANCE CARRIER

THIS COVERAGE IS FOR: ☐ MEDICAL ☐ PRESCRIPTION ☐ VISION

GROUP/POLICY #

THIS PLAN COVERS: ☐ SELF ☐ SPOUSE ☐ CHILD(REN) ☐ STEPCHILD(REN) ☐ OTHER: _____

NAME OF EMPLOYER

Coverage 2

NAME OF POLICYHOLDER WITH OTHER COVERAGE	RELATIONSHIP	NAME OF INSURANCE CARRIER

THIS COVERAGE IS FOR: ☐ MEDICAL ☐ PRESCRIPTION ☐ VISION

GROUP/POLICY #

THIS PLAN COVERS: ☐ SELF ☐ SPOUSE ☐ CHILD(REN) ☐ STEPCHILD(REN) ☐ OTHER: _____

NAME OF EMPLOYER

SECTION 5: MEDICARE INSURANCE INFORMATION

If you or any family members listed on this application have Medicare, please complete the following:

MEMBER'S FIRST NAME	LAST NAME	EFFECTIVE DATE	MEDICARE NUMBER (PLEASE INCLUDE ALPHA PREFIX)

IS MEDICARE COVERAGE: ☐ PART A ☐ PART B

REASON FOR MEDICARE ENTITLEMENT: ☐ AGE ☐ DISABILITY

SECTION 6: LOSS OF OTHER GROUP INSURANCE

If you are applying due to loss of other health coverage, please include a copy of your certificate of coverage and complete the following:

POLICYHOLDER'S FIRST NAME	LAST NAME	RELATIONSHIP	IDENTIFICATION NUMBER

POLICY NUMBER	DATE COVERAGE BEGAN	DATE COVERAGE ENDED	REASON FOR LOSS OF COVERAGE

NAME OF INSURANCE COMPANY/ADDRESS/PHONE NUMBER

THIS COVERAGE WAS AN:

EMPLOYER PLAN: ☐ MEDICAL ☐
INDIVIDUAL PLAN: ☐ MEDICAL ☐

THIS PLAN COVERED (Check all that apply):

☐ FAMILY AS LISTED ON FRONT ☐ OTHER: _____
☐ SELF ONLY ☐ SPOUSE ☐ CHILD(REN) ☐ STEPCHILD(REN)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefit coverage on the enrollment form) 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 be related to treatment of services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care 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 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). A separate authorization will be required for psychotherapy notes.

I certify that the dependents listed on this enrollment form meet the definition of eligible dependents as defined by CIS Trust Policies (see your employer for a copy). I understand that if this application contains material misstatements or omissions, CIS or the insurer may deny coverage, modify or cancel and/or take any other legal action available by law.

I wish to make the elections indicated on this form. I authorize deductions from my wages to cover my contribution, if required, toward the cost of coverage. I understand that my deduction amount will change if my coverage or costs change.

Signature: _____ Date: _____