HEALTHCHOICE

EMPLOYEE ENROLLMENT / CHANGE FORM

***SECTION 1** - To be completed by EMPLOYEE (please type or print). Complete all appropriate boxes.*

EMPLOYEE LAST NAME, FIRST, M.I.		SOCIAL SECURITY NUMBER	HOME PHONE		WORK PHONE
HOME ADDRESS - STREET & NUMBER	APT. NO.	CITY/STATE	ZIP		MARITAL STATUS

MEDICAL PLANS (INDICATE ONE; ALL EMPLOYES MUST ENROLL WITH THE SAME CARRIER)

____HEALTH NET HEALTH PLAN OF OREGON, INC.** ____KAISER PERMANENTE

Health Net - Enhanced Choice Plan Only – Employees must pick one

____Enhanced Choice Plan $750 Ded. ____Enhanced Choice Plan $1000 Ded. ____Enhanced Choice Plan $1500 Ded.

DENTAL PLANS: Available only if your employer has selected for all employees. All employees must enroll with the same Carrier.

For Advantage Dental enrollees, please name prior dental carrier and provide dates of enrollment:

____ From ____________________ to ________________________.

ADD/ DROP	Relationship To Employee	Last Name First M.I.	Date of Birth	Sex	Social Security Number*	Are you eligible for Medicare? (Y/N)
	01 Employee					
	02 Spouse Registered Domestic Partner Non-Registered Domestic Partner					
	03					
	04					
	05					
	06					

Did you and/or any of your Dependents have health insurance prior to enrolling with Health Net or Kaiser?

. No . Yes, attach your Certificate of Creditable Coverage from your current or prior health plan. You may be eligible for prior coverage credit towards pre-existing or other coverage limitations.

Definition: "Creditable Coverage" means health care coverage under a group or individual Health Benefit Plan, Medicare, Medicaid, military-sponsored health care, a medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool, a Federal Employees' Health Benefit Plan (FEHBP), a public health plan, or a Health Benefit Plan under the Peace Corps Act, except coverage consisting solely of coverage of benefits for which credit is not required under applicable law. Coverage is Creditable only if there had not been a gap in coverage exceeding 63 days.

Do you and/or any of your Dependents have health coverage (including Medicare) that will remain in effect after your Health Net or Kaiser coverage begins?

. No . Yes complete and attach your Coordination of Benefits form. Other insured's DOB. / /

If Medicare indicate: . Part A . Part B Effective Date: / / Medicare ID Number ____________________

Complete if enrolling an adopted child or stepchild

Child's complete name and date of adoption/marriage

Complete if enrolling a handicapped Dependent age 19 or over

Handicapped Dependent's name (attach doctor's statement)

I apply for enrollment as indicated on this application. I declare that to the best of my knowledge I am eligible for the coverage requested. I hereby authorize any hospital, health plan, insurer, or other organization or person having any records, data, or information concerning health history or medical insurance for me or my family members to furnish such records, data, or information as may be required by the plan selected, or their duly authorized representative. I authorize any person, organization, health plan or insurance company to furnish or obtain any information regarding benefits to which I may be entitled. I also authorize my employer/group to deduct from my pay the cost for the coverage selected. I have listed all family members to be covered by this program (applies to new enrollment only). The changes on this form supersede all previous forms I have submitted. I certify that the information on this form is true, correct and complete.

Signature of Employee **Date Signed**

*Federal Regulation requires this information for enrollment.

** Health Net Health Plan of Oregon, Inc., 13221 SW 68th Parkway, Tigard, Oregon 97223 • 888-802-7001 • www.healthnet.com

AKT Benefit Advisors LP
680 Hawthorn Ave. SE #140
Salem, OR 97301
Phone: 503.588.0002
Fax: 503.589.9399

*SECTION II--**To be completed by EMPLOYEE If coverage is waived**. (If you waive coverage, you cannot enroll in AOI HealthChoice until the first of the month following the next annual open enrollment period or the loss of coverage under another plan, death of a spouse or divorce.)*

If you are declining coverage for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this plan, provided that you request enrollment within 30 days after your coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If you previously declined enrollment in this plan for yourself or your Dependents because of coverage under a Medicaid plan or CHIP plan, you can enroll within 60 days of loss of such coverage. If you become eligible for premium assistance under a Medicaid plan or CHIP plan, you or your Dependents can enroll in this plan within 60 days of becoming eligible for premium assistance.

WAIVER OF COVERAGE

Employee Name (Last)______________________________(First)______________________(M.I.)________(S.S.#) ______________________

I am waiving coverage at this time (for ____Self ____Dependents) because (complete one of the following):

I/my Dependents have coverage under another plan: ____

I/my Dependents do not have coverage under another plan, but I am not enrolling because: ____

Employee Signature ____ Date Signed ____

SECTION III – To be completed by EMPLOYER

Employer Name ____ Division ____

Employee Date of Hire ____ Employee Class (if applicable) ______________________________

Effective Date of Coverage____ Group Number ______________________________________

Check One ____________Open Enrollment ___________New Employee ______________Change _____________Cancellation

Effective Date of Change or Cancellation____

Check Type of Change which Applies:

_____ Add Dependent
_____ Add/Change Dental coverage
_____ Address Change
_____ Convert to State Continuation
_____ Convert to COBRA: ☐ 18 months ☐ 29 months ☐ 36 months

_____ Name Change
_____ Cancel dental coverage
_____ Reinstatement of Coverage
_____ Cancel All Coverage
_____ Cancel All Dependents
_____ Cancel Named Dependents (as listed by the Employee)

Reason____
____
____

Employer Signature
I certify, to the best of my knowledge, the information reported is true and accurate.

Employer Representative/Title ____ Date ______________________________

Please retain a copy for your records and return original to:

AOI Health*Choice*
P.O. Box 22389
Portland, OR 97269
Ph: 503-968-2360 - Toll Free: 1-866-477-5336
Fax: 503-968-2817 – Toll Free: 1-866-477-5335