



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 EMPLOYEES MUST ENROLL WITH THE SAME CARRIER)

HEALTH NET OF OREGON KAISER PERMANENTE

DENTAL PLANS (SELECT ONE) *If your employer has elected to offer dental coverage to the group, please select one of the following dental carriers:*

ADVANTAGE DENTAL KAISER PERMANENTE

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							
	03							
	04							
	05							
	06							

LIFE INSURANCE BENEFICIARY INFORMATION PLEASE NAME BENEFICIARY(IES) WITH PERCENTAGE OF BENEFIT (include SSN if not listed on this form):

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

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.

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 | _____ Name Change |
| _____ Add/Change Dental coverage | _____ Cancel dental coverage |
| _____ Address Change | _____ Reinstatement of Coverage |
| _____ Convert to State Continuation | _____ Cancel All Coverage |
| _____ Convert to COBRA: _____18 months _____36 months | _____ 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 HealthChoice

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