

# Medical/Dental/Vision Enrollment Form

## ALL EMPLOYEES



**FOR OFFICE USE ONLY**  
 Coverage Effective Date: \_\_\_\_\_  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 SUBJECT TO CARRIER APPROVAL

**Reason for completing form:**

- Open Enrollment
- New Hire
- Add Dependent: Reason \_\_\_\_\_ Date of Event \_\_\_\_\_
- Delete Dependent: Reason \_\_\_\_\_ Date of Event \_\_\_\_\_

*Please complete the following information. Be sure to print clearly.*

1. EMPLOYEE INFORMATION						
Last Name _____		First _____		Initial _____	Date of Birth _____	
Address _____			City _____	State _____	Zip Code _____	
Home Phone _____		Work Phone _____		<input type="checkbox"/> Female	<input type="checkbox"/> Male	
Date of Hire _____		Department _____		Social Security Number _____		
2. MEDICAL PLAN (Choose One)		3. DENTAL PLAN (Choose One)		4. VISION PLAN (Employee ONLY)		
<input type="checkbox"/> Providence <input type="checkbox"/> Kaiser		<input type="checkbox"/> ODS <input type="checkbox"/> Willamette Dental		<input type="checkbox"/> ODS		
5. ENROLLED FAMILY MEMBERS						
<i>List all members of your family enrolled for medical and dental coverage.</i>						
Last Name	First	Initial	Social Security Number	Date of Birth	Gender	Relationship to Employee
Employee _____						
Spouse/Registered Domestic Partner _____						
Dependent _____						
Dependent _____						
Dependent _____						
Dependent _____						
6. OTHER COVERAGE						
<i>If you or your enrolled family members have other group medical or dental coverage or Medicare, please complete the following section.</i>						
Other Medical	Other Dental	Family Member	Other Employer	Is Coverage Still in Effect?	Name of Insurance and Plan Number(s)	
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
7. AUTHORIZATION AND RELEASE OF INFORMATION						

By my signature below, I acknowledge that I have read, approve and agree to be bound by the terms and conditions of the HIPAA Compliant Authorization To Disclose Protected Health Information set forth in full on the reverse side of this document. I declare that the individuals listed on this form satisfy requirements for the selected medical and dental benefits. I declare that the information furnished on this form is true, correct and complete to the best of my knowledge.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

## **HIPAA Compliant Authorization to Disclose Protected Health Information**

I authorize Washington County to disclose any information requested concerning my medical, dental or vision records or other information needed to coordinate or process benefit claims for me and my family members to the insurance carriers listed on this form.

I understand that I have the right to revoke this authorization at any time by notifying Washington County Human Resources Division in writing at 155 N First Avenue, Suite 270, Hillsboro, Oregon 97124-3072. I understand that the revocation is only effective after it is received and logged by Washington County. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

Unless revoked in writing by me, this Authorization will expire upon termination of my participation under Washington County's Health Benefits Plan.

I understand that Washington County cannot disclose the requested information without my signature on this Authorization, and that my signing or refusal to sign this authorization may affect my ability to be enrolled in Washington County's Healthcare Benefits Plan.

I understand that I am entitled to receive a copy of this authorization.

I have the right to refuse to sign this authorization. I understand the potential exists for the information used or disclosed pursuant to this Authorization to be re-disclosed by the recipient and no longer be protected by federal law.

I have reviewed and understand this Authorization.