

CONTINUATION COVERAGE Health Benefits Enrollment Form



FOR OFFICE USE ONLY
Coverage Effective Date:
____/____/____
SUBJECT TO CARRIER APPROVAL

Reason for completing form:

- COBRA Retiree USERRA
 Open Enrollment Name change Address change
 Add Dependent: Reason _____ Date of Event _____
 Delete Dependent: Reason _____ Date of Event _____

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

1. PRIMARY SUBSCRIBER

Last Name _____ First _____ Initial ____ Date of Birth _____
 Address _____ City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____ Female Male
 Date of Hire _____ Department _____ Social Security Number _____

2. MEDICAL PLAN (Choose One) **3. DENTAL PLAN (Choose One)**

- Providence Open Option Plan Kaiser ODS Willamette Dental

4. VISION PLAN (Employee ONLY) **5. OTHER**

- ODS EAP FSA

6. ENROLLED FAMILY MEMBERS

List all members of your family enrolled for medical and dental coverage.

| Last Name | First | Initial | Social Security Number | Date of Birth | Gender | Relationship to Employee |
|------------------------------------|-------|---------|------------------------|---------------|--------|--------------------------|
| Primary Subscriber | | | | / / | | |
| Spouse/Registered Domestic Partner | | | | / / | | |
| Dependent | | | | / / | | |
| Dependent | | | | / / | | |
| Dependent | | | | / / | | |
| Dependent | | | | / / | | |

7. OTHER COVERAGE

If you or your enrolled family members have other group medical or dental coverage or Medicare, please complete the following section.

| 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 | _____ |

8. 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.

Primary Subscriber'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.