Enrollment Application and Change of Information Form
Medical and Dental

ODS use only
Group Number _____
Subscriber Number _____

*Group/Employer _____ *Group ID: _____ *Subgroup ID or Name: _____ *Class: _____

*** Coverage:**

☐ Medical Coverage
☐ Indemnity or PPO (No PCP needed)
☐ Dental Coverage

Type of Application

☐ **New Enrollment or Rehire** Effective Date: _____
☐ **Open Enrollment**
☐ **Term Dependent** Effective Date: _____
Reason: _____
List Dependent(s) to Term in Dependent section.
☐ **COBRA**
Effective Date: _____
Reason: _____

Changes

☐ **Address Change** ☐ **Name Change**
Old Name: _____ New Name: _____

☐ **Add Dependent(s)** - List Dependent(s) to add in Dependent section. Dependent adds require a qualifying event date unless added during open enrollment.

Newborn Birth Date: _____
Adoption Placement Date: _____
(Adoption paperwork required with enrollment)
Marriage Date: _____
(Marriage certificate required with enrollment)
Domestic Partnership Affidavit
Date: _____
(Domestic Partner Affidavit required with enrollment)

Court Appointed Guardian
Date: _____
(Court order of legal guardianship is required with enrollment)
Loss of Group Coverage
Date: _____
(CCC required with enrollment)
Returned to Full-Time Student Status
Date: _____

Please complete this form and sign on the back. Please type or print legibly in ink. Thank you!

* Employee First Name	M.I.	* Last	* Birth date mm/dd/yy	* Gender	* Date of Employment mm/dd/yy
				☐ M ☐ F	

* Employee Mailing Address	* City	* State	* Zip	* Employee Social Security #	Home Phone Number

Primary Language	E-mail Address
☐ English ☐ Spanish ☐ Other: _____	

Relationship code: SP = Spouse, DP = Domestic Partner *(DP only if applicable to your plan)*

Add	Term	Med	Den	* Name * First	M.I.	* Last	* Birth date	* Gender	* Relationship	* Social Security Number	Primary Language (If different from employee)	E-mail Address
☐	☐	☐	☐					☐ M ☐ F	☐ Spouse ☐ DP			
☐	☐	☐	☐					☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐					☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐					☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐					☐ M ☐ F	☐ Child ☐ Ward	N/A		N/A

Other Insurance (Coordination of Benefits)

Will employee or any dependents have **other** insurance?

If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

* Enrollment will be delayed if fields noted in red or with an asterisk are not filled out.

OVER ⇨⇨⇨

Employee Name: ______________________________ SSN: ________________________________

Add	Term	Med	Dent	Name	Birth date	GENDER	Relationship	Social Security Number	Primary Language	Email Address
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐	☐	☐			☐ M ☐ F	Child	N/A		N/A

ODS Enrollment Application

It is VERY important that the employee sign and date below. Thank you!

Are any of the dependent(s) a full-time college student and/or not living with the employee? If yes, please provide the state, zip code and school name if applicable.

Dependent name: .
School Name ____

Dependent name: .
School Name ____

Dependent name: _____State _____ Zip code _____
School Name _____

Dependent name: _____State _____ Zip code _____
School Name _____

Covered Dependent Children Definition

An unmarried child is eligible for coverage if he/she meets the dependent eligibility requirements of the employee's plan. See your Member Handbook for details.

The following are eligible dependent children:

- Your natural child
- Your step-child or adopted child
- Children placed with you for adoption
- Newborns born to a covered dependent, for whom you are financially responsible (legal guardianship is required for coverage after the first 31 days)
- Children related by blood or marriage for whom you are the legal guardian. (You will need to attach a signed court order showing legal guardianship)
- Your domestic partner's natural child or adopted child (if applicable to your employer plan)

Pre-existing Condition Exclusion

(For Members enrolling in Medical Plan)

Were you or any of your dependents covered through another group or individual plan at any time during the past 63 days before your effective date of coverage under this plan, or the first day of any required group eligibility waiting period under this plan?

☐ No ☐ Yes. If yes, please attach your Certificate of Creditable Coverage from your current or prior health plan. A pre-existing period may be reduced by any prior creditable health coverage.

If Prior Medical Coverage Has Been Entered It Will Appear on the Previous Page(s)

Please read and sign below.

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits 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 or 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).

This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 888-447-8187.

REQUIRED

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all the red fields are not filled out entirely.

*** X** _____ *** Date:** _____