PacificSource HEALTH PLANS

Individual and Family Policy Enrollment Form
Washington

Thank you for choosing PacificSource!

You may also enroll online at **PacificSource.com/find-an-individual-plan**.

Before you get started

What you'll need to complete this enrollment form:

- A blue or black pen
- A copy of any documentation you may need to show legal guardianship.
- Your health insurance producer's information, if applicable.
- Your first month's premium payment (required before your policy will take effect).
- Proof of prior coverage if enrolling outside of the open enrollment timeframe. Please provide a certificate of creditable coverage and the prior coverage termination date.

You are eligible to enroll if:

- You and your dependents (if enrolling) are not receiving benefits under Medicare Part A, Medicare Part B, nor enrolled in a Medicare Choice or Advantage plan.
- You are a resident of the state Washington residing in Clark, Pierce, or Spokane county.
- Your spouse/domestic partner (if applicable) is your legal spouse/domestic partner.
- You or your legal spouse/domestic partner's children (if applicable) are your natural or adopted children, or you are their legal guardian.

Please note: If you are eligible for federal financial assistance, you must apply for coverage through Washington Healthplanfinder at wahealthplanfinder.org.

Need help?

If you have questions about any part of this enrollment form, we'd be happy to help. You can reach a PacificSource Coverage Advisor at **(855) 330-2792**.

What Happens After You Submit Your Application

We'll begin processing your application, and in the coming weeks, if you have met the qualifications and payment has been received, you'll receive a few things from us. To get information faster, include your email address in your application.

1. A Summary of Benefits and Coverage
2. New Member Information
3. Your ID card(s)
4. Your full policy

Please keep a copy of this application for your records.

1 What type of coverage would you like?

New Coverage

- ☐ For myself only
- ☐ For myself + my spouse/domestic partner
- ☐ For myself + my family
- ☐ For my child(ren) or legal dependent(s) only

Or Change to My Current Coverage

Current PacificSource ID No. _____
(This can be found on your ID card.)

- ☐ Add family member(s) (Complete section 7)
- ☐ Change my plan as shown below

Enrolling due to ☐ Qualifying event (please explain below) ☐ The Open Enrollment Period

Qualifying Event _____ Date of Event _____/_____/_____

Documentation is required if enrolling outside of the open enrollment period, or adding dependents. If you apply during open enrollment, coverage will be effective January 1. If you apply during special enrollment, coverage will be effective first of the month following the qualifying event unless your qualifying event allows you to enroll on the date of the qualifying event.

2 Choose a medical plan

For plan benefit information, please visit **PacificSource.com/find-an-individual-plan** or refer to our Washington Individual and Family Plan brochure.

Navigator Network

- ☐ Bronze HSA 6750
- ☐ Bronze 7000
- ☐ Silver 5000
- ☐ Silver 3500
- ☐ Gold 1500

3 Select a coverage date

What date would you like the coverage to begin? _____/_____ Mo/Yr.
Coverage will be active on the first of the month.

If you are enrolling during open enrollment, your application must be turned in by Dec. 15th for a Jan. 1st effective date.

If you are applying outside of open enrollment, you have 60 days from your qualifying event to apply and then your plan will start the first of the month following that qualifying event. If qualifying event is due to the birth, adoption, or foster placement of a new dependent, then coverage is effective on the day of the event.

Enrolling myself and my family

List all family members you would like insured. Only your legal spouse, domestic partner, and dependent children are eligible. If a child is over the age of 26 and medically certified as disabled and dependent on parents, a copy of a certification is required.

*__Race/Ethnicity__ (This is Optional. This is used for NCQA purposes only. Choose the code that each family member would most closely identify with): **AI**-American Indian/Alaska Native, **A**-Asian, **B**-Black/African American, **H**-Hispanic/Latino, **N**-Native Hawaiian/Other Pacific Islander, **W**-White/Caucasian.

**Use of tobacco on average four or more times per week within the past six months. Includes all tobacco products, except for religious or ceremonial use.

Individual pediatric dental coverage is required for all dependents under 19 years of age

☐ I will purchase dental coverage from another insurance carrier

☐ No, I will not enroll any individual under age 19 on this plan

4 Myself (Required)

If this is a child/dependent only policy, PacificSource requires the responsible parent or guardian to include their information.

Name (First, MI, Last) _____

Gender (M/F) _____ Social Security No. _____

Race/Ethnicity* _____ Date of Birth (MM-DD-YY) _____

Marital Status ☐ Single ☐ Married ☐ Domestic Partnership

Physical Address _____

City _____ State _____ ZIP _____ County _____

Phone _____ Email _____

Mailing Address (if different) _____

City _____ State _____ ZIP _____

Primary Care Provider Name*** _____

Primary Care Provider Address*** _____

Are you a current patient? ☐ Yes ☐ No

Do you use tobacco products?** ☐ Yes ☐ No

Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

*** Not required for plan enrollment. Used for coordinating care with member's dedicated care team.

5 Spouse or Domestic Partner (Skip to section 7 if not enrolling a spouse or domestic partner.)

Name (First, MI, Last) _____

Gender (M/F) _____ Social Security No. _____

Race/Ethnicity* _____ Date of Birth (MM-DD-YY) _____

Primary Care Provider Name*** _____

Primary Care Provider Address*** _____

Are you a current patient? ☐ Yes ☐ No
Do you use tobacco products?** ☐ Yes ☐ No
Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

6 Dependent Child (Skip to section 8 if not enrolling dependents.)

Name (First, MI, Last) _____
Gender (M/F) _____ Social Security No. _____
Race/Ethnicity* _____ Date of Birth (MM-DD-YY) _____
Primary Care Provider Name _____
Primary Care Provider Address _____

Are you a current patient? ☐ Yes ☐ No
Do you use tobacco products?** ☐ Yes ☐ No
Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Dependent Child

Name (First, MI, Last) _____
Gender (M/F) _____ Social Security No. _____
Race/Ethnicity* _____ Date of Birth (MM-DD-YY) _____
Primary Care Provider Name _____
Primary Care Provider Address _____

Are you a current patient? ☐ Yes ☐ No
Do you use tobacco products?** ☐ Yes ☐ No
Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Dependent Child

Name (First, MI, Last) _____
Gender (M/F) _____ Social Security No. _____
Race/Ethnicity* _____ Date of Birth (MM-DD-YY) _____
Primary Care Provider Name _____
Primary Care Provider Address _____

Are you a current patient? ☐ Yes ☐ No
Do you use tobacco products?** ☐ Yes ☐ No
Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Attach additional pages if needed ☐ I have attached _____ pages

7 My Other Insurance Information

Please list the most recent health or dental insurance coverage you, or any family members listed on this enrollment form, have had including commercial (employer group or individual insurance), Medicaid, Medicare, Medicare Advantage, Medicare supplemental or Pediatric Dental coverage.

☐ No Prior Coverage

Name of other insurance company(ies) (include address and phone if available)

_____

Type of Coverage (check all that apply)

☐ Medical ☐ Vision ☐ Pediatric Dental ☐ Adult Dental

Name(s) of individual(s) covered

_____

Date coverage began _____/_____/_____ Date coverage ended _____/_____/_____

Is coverage active? ☐ Yes ☐ No Policy No. _____

If group insurance, name of group _____

8 Certify, Authorize, and Sign

Be sure to sign and date the enrollment form on this and the following page. Your spouse or domestic partner's signature is also required (if applicable) as is the signature of any child over the age of 18. Representations made by the enrollee are deemed to be representations made on behalf of each person covered under this policy. However, changes to the enrollment form will not be effective until approved in writing by the enrollee. You may request a free paper copy of your application and/or enrollment information by contacting our Commercial Enrollment and Billing Department via email at **individual@pacificsource.com** or by phone at **(866) 695-8684.**

Certification of Completeness and Correctness
It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

I affirm that the answers given in this enrollment form are complete and correct and, if this form includes any intentional misrepresentation of material fact or fraud, PacificSource may modify or cancel the contract, and/or take any other legal action available by law. If accepted, coverage will be in force as of the effective date determined by PacificSource. A representative of PacificSource may contact me to clarify answers on this enrollment form.

I (We) have reviewed and understand the authorization above.

Enrollee/Responsible Party/Guardian Signature _____ Date _____

Printed Name _____ Relationship _____

If enrolling in coverage:

Spouse/Domestic Partner Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

Required if enrollee is a minor:

Printed name of ☐ Parent or ☐ Guardian _____

Signature _____ Date _____

This enrollment form must be signed and dated. All fields must be completed for this authorization to be valid. Once accepted, PacificSource will provide the policyholder with a copy of this completed form with the policy.

9 Producer Authorization (Skip to section 11 if you are not working with a producer.)

I, the insurance producer, have not made any representations to the enrollee about any provisions, benefits, conditions, or limitations of the policy except through written material furnished by PacificSource. The enrollee has been informed that the effective date of coverage is assigned only by PacificSource. I hereby certify that information supplied to me by the enrollee has been truly and accurately recorded hereon.

Enrollee's Name (printed) _____

Producer's Name (printed) Rebecca J Humphrey

PacificSource Producer No. PM0117001

Producer's Signature _____ Date _____

10 How Do You Prefer to Pay for Future Premiums?

Your first month's premium must be received by check or money order before your policy will take effect. We will not accept third party payments except as required by federal law.

Please select your method of payment for future premium payments. Reminder: Your first month's premium can only be paid with a check or money order.

☐ Send me a paper bill by mail each month *(Skip to section 12)*

☐ Automatic withdrawal from my bank account, Electronic Funds Transfer (EFT). *The first month's payment cannot be made by EFT.*

We authorize and direct PacificSource Health Plans to withdraw funds as follows:

Amount of monthly withdrawal $_____ Withdrawals will occur on the 5th of each month.

Select one: ☐ Begin transfers on next available date ☐ Delay transfers until _____(Mo.)

Bank information

Bank Name _____

Account No. _____ Routing No. _____

Account Type

☐ Checking—Attach a voided check ☐ Savings—Attach a voided savings withdrawal slip

This authorization will remain in effect until termination by either party. If the individual policy premium changes due to a rate increase, alternate plan selection, or age change of the policyholder, this authorization will automatically be amended to authorize withdrawal of an amount equal to the new premium.

Policyholder's Name (printed) _____ Date _____

Signature of Bank Account Holder _____ Date _____

Important details about the automatic withdrawal of your monthly premiums:

- New accounts may take 30 days to set up. If your policy is accepted and coverage starts sooner than your automatic withdrawal is set up, you may need to pay by check until the funds transfer is in place.
- Transfers occur on the 5th of each month. If the 5th falls on a weekend or a holiday, the transfer will occur on the next business day.
- Transfers will be made for the premium balance due.
- If EFT is not set up prior to the bill date of the second month, you may receive a paper bill for the second month.

11 Are You Ready to Submit?

- ☐ Are all sections filled in completely?
- ☐ Have you attached requested paperwork (i.e., guardianship documentation, etc.)?
- ☐ Did you select a policy coverage date on page 2?
- ☐ Have you included a check or money order for your first month's premium payment?
- ☐ Have you selected an ongoing payment option and attached a voided check if needed? (See section 11)

Send your signed, completed enrollment form and attachments to us by:

Email: Individual@pacificsource.com
Fax: (541) 225-3646
Mail: PacificSource Health Plans, PO Box 7068, Springfield, OR 97475-0068

Thank you for enrolling!

Office use only

Washington law (RCW 48.43.510) requires an offer of certain health plan information before purchase or selection of a health plan. You can review that information at **https://pacificsource.com/plan-summaries/** or request from our Customer Service Department **866-556-1224**. Available information concerns benefits, required preauthorizations, premiums and cost sharing, in-network providers, appeals and grievances, accreditation, and confidentiality. If you wish to purchase coverage through the Health Benefit Exchange, you must apply directly through them.

Discrimination Is Against the Law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PacificSource:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Customer Service at (888) 977-9299 or, for TTY users, (800) 735-2900, 7:00 a.m. to 5:00 p.m.

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, (888) 977-9299, TTY 711, fax (541) 684-5264, or email crc@pacificsource.com. Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the PacificSource Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at OCRPortal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at HHS.gov/ocr/office/file/index.html.

Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (888) 977-9299 (መስማት ለተሳናቸው: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (888) 977-9299 (رقم هاتف الصم والبكم: 711).
Bantu	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (888) 977-9299 (TTY: 711).
Cambodian	បពេ ប្រយ័ត្ន៖ សិនជាអ្នកនិយាយ ភាសាខ្មែរ, សជាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (888) 977-9299 (TTY: 711)។
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (888) 977-9299 (TTY: 711)。

Cushite-Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (888) 977-9299 (TTY: 711).
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez (888) 977-9299 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (888) 977-9299 (TTY: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (888) 977-9299 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(888) 977-9299 (TTY:711）まで、お電話にてご連絡ください。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (888) 977-9299 (TTY: 711)번으로 전화해 주십시오.
Laotian	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສຽັຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (888) 977-9299 (TTY: 711).
Nepali	ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (888) 977-9299 (टटिविइ: 711) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring (888) 977-9299 (TTY: 711).
Pennsylvania Dutch	Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call (888) 977-9299 (TTY: 711).
Persian-Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با (888) 977-9299 (TTY: 711) تماس بگیرید.
Punjabi	ਧਆਿਨ ਦਓਿ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਚਿ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (888) 977-9299 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (888) 977-9299 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (888) 977-9299 (телетайп: 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezi**č**ke pomo**ć**i dostupne su vam besplatno. Nazovite (888) 977-9299 (TTY–Telefon za osobe sa o**š**te**ć**enim govorom ili sluhom: 711).
Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 977-9299 (TTY: 711).
Tagalog	UNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (888) 977-9299 (TTY: 711).
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (888) 977-9299 (TTY: 711).
Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (888) 977-9299 (телетайп: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (888) 977-9299 (TTY: 711).