PacificSource Health Plans
Individual and Family Dental Policy Application

Thank you for choosing PacificSource! You may also apply online at **PacificSource.com/find-a-plan**.

1. What you'll need to complete this application:

- A blue or black pen.
- Information, such as your old ID card, from any insurance company that currently or recently covered you or your family.
- A copy of any documentation you may need to show legal guardianship. If you are part of an unregistered domestic partnership, attach an Affidavit of Domestic Partnership (found on our website under For Employers > Forms and Materials > Administrative Forms).
- The name of your primary care dentist for all family members applying.

2. You are eligible to apply if:

- ☑ You are under age 65 or otherwise not eligible for Medicare.
- ☑ You are a resident of the state of Oregon.
- ☑ Your spouse/domestic partner (if applicable) is your legal spouse or registered domestic partner. (See #1 for unregistered domestic partners.)
- ☑ Your children (if applicable) are your natural or adopted children, under age 26 or you are their legal guardian.
- ☑ Your employer will not be paying, or reimbursing you for, any part of the premium.
- ☑ You do not have other dental insurance, or you will be cancelling any other dental insurance if you are accepted for a PacificSource policy.

3. Where to send this application when you've finished:

Mail: PacificSource Health Plans
PO Box 7068
Springfield, OR 97475-0068

Fax: (541) 225-3646

Email: individual@pacificsource.com

Fax Completed Application to 503-488-5597
or mail to:
Health Benefits Solution, Inc
5200 SW Meadows Rd, Suite 150
Lake Oswego, OR 97035

PacificSource HEALTH PLANS

4. What type of coverage would you like?

New Coverage

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

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

OR

Change to my Current Coverage

Current Member ID #_____

☐ Add family member(s)

Reason/Qualifying Event:

Date of Qualifying Event:

☐ Change my plan as shown below

Choose a plan and a deductible (check one):

Dental Advantage Network

- ☐ Dental Advantage 0/20/50/50
- ☐ Kids Dental Advantage 20/40/50/50 (through age 18)

What date would you like the coverage to begin? ☐ 1st or ☐ 15th of _____/_____Mo/Yr

This policy includes pediatric dental coverage that meets the requirements of the Affordable Care Act.

Would you like to apply for a PacificSource Individual medical policy? ☐ Yes ☐ No If yes, please complete an Individual and Family Application, also.

5. Enrolling Myself and My Family

List all family members you would like insured. Only your legal spouse, domestic partner, and dependent children are eligible.

***Race/Ethnicity** (choose the code that each family member would most closely identify with): **A**-American Indian/Alaska Native, **B**-Asian, **C**-Black/African American, **D**-Hispanic/Latino, **E**-Native Hawaiian/Other Pacific Islander, **F**-White/Caucasian

Name (First, MI, Last)	Gender (M/F)	Race/ Ethnicity*	Social Security Number	Date of Birth (MM-DD-YYYY)
Myself:				
Marital status: ☐ Single ☐ Married ☐ Registered Domestic Partnership ☐ Unregistered Domestic Partnership (affidavit of domestic partnership required)				Email:
Address:	City:		State:	Zip: / County:
Mailing address (if different):				Phone:
Name (First, MI, Last)	**Gender (M/F)**	**Race/ Ethnicity***	**Social Security Number**	**Date of Birth (MM-DD-YYYY)**
My spouse or domestic partner:				
My dependent child:				

Name (First, MI, Last)	Gender (M/F)	Race/ Ethnicity*	Social Security Number	Date of Birth (MM-DD-YYYY)
My dependent child:				
My dependent child:				
My dependent child:				
My dependent child:				
My dependent child:				

Attach additional pages if needed. ☐ I have attached ___ page(s).

6. Choose a Primary Care Dentist if an Essential Dental Plan is Chosen

Applicant Name:	Primary Care Dentist (Name/Address)	Current Patient?
Me:		☐ Yes ☐ No
My spouse or domestic partner:		☐ Yes ☐ No
My dependent child:		☐ Yes ☐ No
My dependent child:		☐ Yes ☐ No
My dependent child:		☐ Yes ☐ No
My dependent child:		☐ Yes ☐ No
My dependent child:		☐ Yes ☐ No

Attach additional pages if needed. ☐ I have attached ___ page(s).

7. My Other Insurance Information

A. Do you, or any people listed on this application, have other active health insurance coverage, including Medicare, Medicare Advantage, or Medicare supplemental coverage? ..... ☐ Yes ☐ No

Name of other insurance company (include address and phone number if available):	
Name(s) of individual(s) covered under the policy:	
Date coverage began: ____/____/____ Date coverage ended: ____/____/____ ☐ Coverage is still in effect	Policy number: If group insurance, name of group:

Reminder: Any other active coverage must be terminated before you can be issued a PacificSource individual and family plan.

B. Do you, or any people listed on this application, work for an employer who offers health insurance benefits to employees? ..... ☐ Yes ☐ No

Are you, or any people listed on this application, enrolled in the employer's plan? ..... ☐ Yes ☐ No

If no, why?_____

Need help? ***If you have questions about any part of this application, we'd be happy to help. You can reach an Individual Sales Representative at (866) 695-8684.***

8. How Do You Prefer to Pay?

☐ Send me a paper bill by mail each month. (Continue to section 9.)

☐ Through automatic withdrawal from my bank account (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 the next available date ☐ Delay transfers until_____(month)

Bank information:

Bank name: _____ Account number: _____

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 (please print)

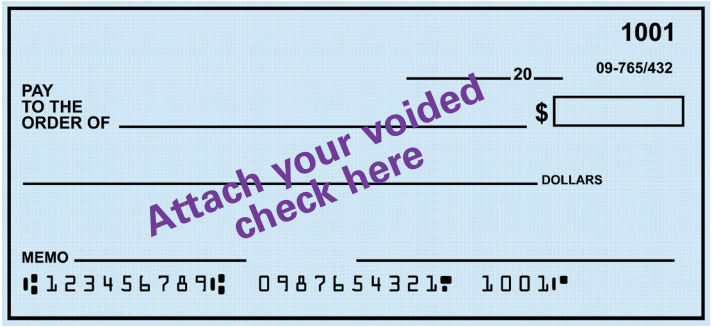
_____ Signature of Bank Account Holder

_____ Policyholder's ID

_____ Date

Important details about the automatic withdrawal of your monthly premiums:

- New accounts 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.



9. Certify, Authorize, and Sign

Be sure to sign and date the application on the following page. Your spouse's or domestic partner's signature is also required (if applicable) as is the signature of any child over the age of 18.

Certification of Completeness and Correctness

I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by PacificSource to enroll in their insurance coverage. I understand that if this application contains any intentional misrepresentation of material fact or fraud, PacificSource may modify or cancel the contract, and/or take any other legal action available to it by law. I will promptly inform PacificSource in writing if anything happens before my coverage takes effect that makes the information I have provided on this application incomplete or incorrect. I understand and agree that no coverage will be in force until accepted by PacificSource. 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 application. Representations made by the applicant are deemed to be representations made on behalf of each person covered under this policy. However, changes to the application will not be effective until approved in writing by the applicant. An application received by PacificSource requiring alterations will be modified by amendment and sent to the applicant for signature. As the applicant, I understand I have the right to inspect the information in my file.

I (We) have reviewed and I (we) understand this authorization and the "Certification of Correctness" above.

Applicant/responsible party/guardian Signature _____ Date _____

Spouse's/Domestic Partner's Signature (if applying for coverage) _____ Date _____

Signature of child age 18 or older (if applying for coverage) _____ Date _____

Signature of child age 18 or older (if applying for coverage) _____ Date _____

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

Required if applicant is a minor:

Signature of (check one) _____ Date _____ Printed Name of Parent or Guardian _____

☐ Parent ☐ Guardian

10. Are You Ready to Submit?

☐ Are all sections filled in completely?

☐ Have you attached any requested paperwork (such as guardianship documentation, Affidavit of Domestic Partnership, etc.)?

☐ Have you selected a payment option and attached a voided check if needed?

☐ Did you select a policy effective date on page 2?

11. Submit

Send your signed, completed application and attachments to us by:

Mail: PacificSource Health Plans
PO Box 7068
Springfield, OR 97475-0068

Fax: (541) 225-3646

Email: individual@pacificsource.com

Fax Completed Application to 503-488-5597
or mail to:
Health Benefits Solution, Inc
5200 SW Meadows Rd, Suite 150
Lake Oswego, OR 97035

Thank you for your application!

12. Producer Authorization

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

Applicants name (printed)

Doug Ellsworth
Producer's Name (printed)

P00096401
PacificSource Producer Number

Doug Ellsworth "Signature"
Producer's Signature

Date

Office use only