



# Enrollment Application and Change of Information Form — Northwest Plan Administrators

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



Group/Employer Name	Group # (complete if known)	Union Name (complete if known)	Date of Employment
Federal Employees Dental Plan	D802		

Employee Name First M.I. Last	Birth date	Gender	Employee Social Security #
		<input type="checkbox"/> M <input type="checkbox"/> F	
Employee Mailing Address Address	City	State	Zip
			Home Phone Number
			( )

### Dependent information (If terminating dependents, please list those dependents to remove from coverage)

Name First M.I. Last	Birth date	Gender	Relationship (Spouse, child, ward, etc.)
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	

### Other Insurance (Coordination of Benefits)

Will employee or any dependents have **other** dental insurance?  Yes (If yes, you must complete the Other Insurance Coverage form)  No Other Dental Insurance

**Coverage:**  
 Dental Coverage

**Type of Application:**  
 New Enrollment or Rehire  
Effective Date: \_\_\_\_\_

**Changes:**  
 Address Change  
 Name Change  
Effective Date: \_\_\_\_\_  
New Name: \_\_\_\_\_  
Old Name: \_\_\_\_\_

Add Dependent(s) - List dependent(s) to add in dependent section and qualifying event date\*.  
Newborn Birth date: \_\_\_\_\_  
Adoption Date: \_\_\_\_\_  
Marriage Date: \_\_\_\_\_  
Court-Appointed Guardian  
Date: \_\_\_\_\_  
Loss of Group Coverage  
Date: \_\_\_\_\_

\* Dependent adds require a qualifying event date unless added during open enrollment.

Terminate Dependent(s) - List dependent(s) being terminated in dependent section, date and reason.  
Term Date: \_\_\_\_\_  
Reason: \_\_\_\_\_

OVER



# ODS Enrollment Application

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

## Covered Dependent Children Definition

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

**The following are eligible dependent children:**

- Your natural child
- Your step-child, foster 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.)

**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 503-243-4492.

REQUIRED

X

Date:

**COORDINATION OF BENEFITS**

**O.D.S DENTAL PLAN**



TO COORDINATE BENEFITS BETWEEN O.D.S. DENTAL AND YOUR FEDERAL EMPLOYEE HEALTH BENEFIT (F.E.H.B) PLAN WITH DENTAL BENEFIT, WE WILL NEED THE FOLLOWING INFORMATION:

**PERSONAL INFORMATION**

YOUR NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

HOME PHONE #: (\_\_\_\_) \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

CURRENT DENTAL PLAN WITH N.W.PA. (IF APPLICABLE): \_\_\_\_\_

LEVEL OF O.D.S.  COVERAGE APPLYING FOR:

- MEMBER
- MEMBER + 1
- MEMBER + CHILDREN
- MEMBER + FAMILY

**F.E.H.B. PLAN INFORMATION FOR CURRENT YEAR**

NAME OF HEALTH PLAN: \_\_\_\_\_

DOES THE PLAN HAVE A DENTAL RIDER?     YES     NO

PLEASE MAIL COMPLETED FORM TO:

NWPA  
1805 TABOR ST  
EUGENE, OR 97401

**AFFIDAVIT OF DOMESTIC PARTNERSHIP**

I, (print name of employee) \_\_\_\_\_, certify that I and (print name of domestic partner) \_\_\_\_\_ (check and complete either A. or B., whichever applies):

- A. \_\_\_\_\_ have a Common Law Marriage recognized under Oregon law as follows:
- B. \_\_\_\_\_ are and have each been the other's partner in a domestic partnership, as defined below. For purposes of this affidavit, a "domestic partnership" is one consisting of two persons in which the members:
  1. Jointly shared the same permanent residence for at least six (6) months immediately preceding the date of this affidavit and intend to continue to do so indefinitely;
  2. Have a close personal relationship with each other;
  3. Are not legally married to anyone;
  4. Are each eighteen (18) years of age or older;
  5. Are not related to each other by blood in a degree of kinship closer than would bar marriage in the State of Oregon;
  6. Were mentally competent to contract when the domestic partnership began;
  7. Are each other's sole domestic partner; and
  8. Are jointly responsible for each other's common welfare including "basic living expenses." For purposes of this affidavit, "basic living expenses" means the cost of basic food, shelter, and any other expenses of a member of the domestic partnership which are paid at least in part by a program or benefit for which the partner qualified because of domestic partnership. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

This affidavit terminates upon the death of the signing employee's domestic partner or by a change in circumstances attested to in this affidavit. A letter documenting the termination of domestic partnership must be filled out by the signing employee and submitted within thirty (30) days after such death or change to the employer. After filing the termination of domestic partnership, the employee may not file a new Affidavit of Domestic Partnership for the purpose of enrolling a new domestic partner for six (6) months from the date letter of termination is received.

**Notice:** *Signing this affidavit may or may not have legal implications affecting relations between domestic partners beyond the extension of medical or dental insurance coverage for which it is intended. If you desire further information concerning the possible legal consequences of signing this form, please consult an attorney.*

I attest that the certification I have provided herein is true and correct to the best of my knowledge.

\_\_\_\_\_  
 (Employee's signature) (Date)

Received By: \_\_\_\_\_  
 (Group Administrator) (Date)