



Medical and Dental Enrollment Form

SEIU Local 503, OPEU PO Box 12159, Salem, OR 97309-0159 Telephone: (503) 364-HUBB (4822) or (866) 364-HUBB (4822) Fax: (503) 581-1664

Complete all sections of this form.

Section A Employee Information (PLEASE PRINT)

New Enrollee

Re-enrollment

Name (Last) _____ (First) _____ MI _____ | _____ - _____ - _____ | _____ | _____

Home Address _____ City _____ State _____ Zip Code _____

Mailing Address (if different) _____ City _____ State _____ Zip Code _____

Residence County _____ Home Phone (_____) _____ Alternate Phone (if available) (_____) _____

Birth Date ____/____/____ Gender M F | Email Address _____

Section B Medical & Dental Plan Election (based on your service area)

Select a Medical Plan: Kaiser Permanente Medical HMO
For employees who reside within the Kaiser service area.

ODS Medical Plan
For employees who reside outside the Kaiser service area.
Primary Care Provider _____

Select a Dental Plan: Kaiser Permanente Dental Plan
For employees who reside within the Kaiser service area.

Oregon Dental Service (ODS)
For employees who reside anywhere in the state of Oregon.

Section C Dependent Plan Election (optional coverage, employee contribution required)

List all eligible dependents you wish to cover. If covering a domestic partner, partner's children, or dependent child by court or administrative order, appropriate documentation must be attached or on file. Enter the appropriate relationship key to identify their relationship to you. You pay the additional monthly premium.

Relationship key: **SP**=spouse, **DP**= domestic partner, **CH**=employee and/or spouse's child, **DPCH**= domestic partner's child, **DOCCH**=child by documentation

Name (Last, First, MI)	SSN	Birthdate	Gender	Relationship (See Key above)	Plan Election		If enrolled in ODS Medical Plan, indicate a Primary Care Physician (PCP)
					Medical & Dental	Medical Only	
			M / F		<input type="radio"/>	<input type="radio"/>	
			M / F		<input type="radio"/>	<input type="radio"/>	
			M / F		<input type="radio"/>	<input type="radio"/>	
			M / F		<input type="radio"/>	<input type="radio"/>	

Attach page for additional dependents.

Section D Other Medical and Dental Coverage

Are you or any of your dependents covered through another group or individual plan? Medical no yes (if yes, complete the following):
Dental no yes (if yes, complete the following):

Person(s) with other coverage _____

Insurance Company Name _____ Employer Name _____

Policy # _____ Group # _____ Effective Date _____ End Date _____

Are you or a dependent covered by Medicare or Veteran's Benefits? yes no

Were you or any of your dependents covered through another group or individual plan at any time during the past 63 days before your enrollment date on this plan?
 NO YES (Attach your Certificate of Creditable Coverage from your current or prior health plan. A preexisting period may be reduced by any prior creditable health coverage.)

Section E Authorization (I understand and authorize)

My benefit elections, as indicated on this form, are in effect as long as eligibility requirements are met or until I elect to change them subject to provisions of the plan.

I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations and provisions of the HUBB insurance program. My signature further acknowledges that HUBB, FHIAP and the insurance carriers may request or disclose health information about me from time to time for the purpose of facilitating health care payment or treatment or for the purpose of business operations necessary to administer health care benefits. My signature authorizes HUBB, FHIAP and the State of Oregon, as applicable, to use my and the members of my family's Social Security Numbers (SSN) and to disclose my SSN to others as needed to confirm eligibility.

This authorization will remain valid until I sign and submit a new Medical and Dental Enrollment Form.

Employee Signature _____

Date _____

Please keep a copy for your records.

04/11 HUBB

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