

**Reed College  
Medical/Dental Enrollment Form**

**Administrator Use Only**

**Effective Date:** \_\_\_\_\_

**HIRE Date:** \_\_\_\_\_

**Number of Hours Worked:** \_\_\_\_\_

- New Employee / Open Enrollment
- Add Dependent..birth / marriage / adoption
- Cancel Dependent..marriage / divorce / student status
- Employee Termination
- Other
- Transfer to COBRA ....18 mos / 29 mos / 36 mos

**COBRA effective date:** \_\_\_\_\_

**COBRA Termination Codes:**

- DC=Dependent Child(ren)      TE=Termination
- DV=Divorce                      DE=Death
- MI=Medicare Ineligible      DX=Disability Extension
- RH=Reduction in Hours

**(QE Code):** \_\_\_\_\_ **Location:** \_\_\_\_\_

Name (Last, First): \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M / F

Home Address: \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (zip) \_\_\_\_\_

Marital Status: \_\_\_\_\_ Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

**MEDICAL:**  PEHT PPO Plan : Preferred Provider network

Kaiser HMO Plan

**DENTAL :**  PEHTFee For Service Plan  Kaiser Dental (Kaiser Providers Only)

Willamette Dental Plan

Medical U	Den U	Name: (Last, First, Middle Initial)	Relationship	Social Security Number	Occupation	Sex	Date of Birth	FT Student?
			Self					
			<input type="checkbox"/> Spouse / <input type="checkbox"/> Domestic Partner					
			Child					Y / N
			Child					Y / N
			Child					Y / N
			Child					Y / N

**Do you or any of your dependents applying for coverage have coverage (now, or within the past 3 months) with any health care plan?**  Yes  No

**If you or your dependents have had coverage through ANY health care plan during the past 3 months, you MUST complete the following:**

Other Insurance: Company: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Date Coverage Began: \_\_\_\_\_ Date Coverage Ended: \_\_\_\_\_  
 Persons Covered: \_\_\_\_\_

**Refusal of Insurance:** I understand that if I refuse coverage, my ability to obtain benefits under health plans may be restricted by the guidelines set forth by each carrier.

**I decline the following coverage(s) for myself:**  Medical  Dental I am declining because - I have coverage elsewhere YES / NO (please circle)  
**I decline the following coverage(s) for my dependents:**  Medical  Dental Declining coverage because – dependents are covered elsewhere YES / NO (please circle)  
**Dependents declining :**  spouse only  spouse & children  children only

**Insurance Waiver:**  Medical \$300 per plan year, pro-rated for part time  Dental \$60 per plan year, pro-rated for part time

*I hereby verify that all of the information specified above is accurate and complete. I have also read and understood the Application Agreement and Release of Information on the reverse side of this application.*

**X Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested. My signature also verifies the accuracy of the information on this form.
- I understand all premiums to be paid by me\* will be deducted on a pre-tax basis from my paycheck unless I contact the payroll department and request otherwise. (*\*Premiums for domestic partner coverage will not be deducted with pre-tax dollars.*)
- If I declined all or a portion of any of the offered benefits, I understand that I will be subject to restrictions upon subsequent applications and may need to provide satisfactory evidence of insurability.
- I understand that I must satisfy the eligibility and actively at work requirements at my employer's' usual place of business on the date coverage for myself and any eligible dependents (if any) become effective. If I am not actively at work, I understand that coverage for myself and eligible dependents will not become effective until I return to work.
- I realize that, whether or not proof of good health is required upon a subsequent application, coverage will be subject to the pre-existing conditions limitation, if any under the plans.
- I realize that my Section 125 election is binding for the entire plan year and can only be changed due to a change in family status.
- Each of the benefit plans is governed by an official plan document. If any discrepancies arise between any summaries and the official plan document, the official plan document will be regarded as the final authority.

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 Psychotherapy Notes. A separate authorization will be used for this information.