Multnomah Bar Association
Enrollment application & change of information form

IF ATTORNEY PLEASE PROVIDE OSB #

To expedite your application, please print legibly in black or blue ink and return as instructed. Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed.

Section 1> Application type

You'll need a special enrollment reason for some changes made outside the open enrollment period. Special enrollment includes adding dependents to an existing plan and enrolling in the plan due to loss of other coverage. The reason I am applying or making a change is:

Open enrollment

☐ New policy/subscriber
☐ Add dependent on existing plan
☐ Delete dependent

Changes

☐ Name change

New name: ___________________________

Old name: ___________________________

____ New address
(please write new address in Section 3)

Special enrollment

Date of event:_____ /_____ /_____

☐ Marriage
☐ Registered domestic partner (RDP)
☐ Birth, adoption or placement for adoption
☐ Loss of coverage because I turned 26
☐ Loss of coverage due to end of marriage or registered domestic partnership (RDP)
☐ Involuntary loss of group coverage
☐ COBRA ended due to exhausting benefit
☐ Other ___________________________

Section 2 > Coverage

DENTAL COVERAGE
ODS Dental using
Delta Dental PPO Dentists

VISION/OPTICAL COVERAGE
Vision Service Plan
VSP Signature Doctor Network

INDICATE CHOICE BELOW

DENTAL ONLY ____________

DENTAL AND VSP _________

Group Name: **Multnomah Bar Association**	Group Number: **10001777**

Section 3 > Employee information

First Name	M.I.	Last Name	Social Security No.

Mailing Address	City	State	ZIP

Home Phone	Date of Birth (mm/dd/yyyy)	Gender F ☐ M ☐	Date of Employment (mm/dd/yyyy)

Primary Language ☐ English ☐ Spanish Other_______________	Email Address

Section 4 > Dependents

Relationship code: SP = spouse DP = domestic partner, RDP = registered domestic partner

Add	Term	[1]Dependent first name	*Last	*Social Security number	Date of birth (mm/dd/yyyy)	*Gender	*Relationship	Primary language (if different from employee)
						F ○ M ○		
						F ○ M ○		
						F ○ M ○		
						F ○ M ○		
						F ○ M ○		

1Please list only eligible dependent children. See Section 6 for dependent children qualifications.

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Section 5 > Other insurance (coordination of benefits)

Will employee or any dependents have other insurance? ☐ Yes ☐ No

Section 6 > Dependent(s) not living with employee

Are any of the dependent(s) not living with the employee? If yes, please provide the state and ZIP code. This is for informational purposes only and does not impact eligibility.

Dependent name	State	ZIP
Dependent name	State	ZIP
Dependent name	State	ZIP
Dependent name	State	ZIP

Children are eligible to enroll for coverage through age 25.Please see your Member Handbook for additional eligibility information.
The following are eligible dependent children:

> Your or your spouse's natural 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 31days) > 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) > Your domestic partner's natural child or adopted child (if domestic partners by affidavit can enroll in your employer plan)

> Your registered domestic partner's natural child or adopted child

Section 7 > Authorization (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. It is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of health coverage.

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all fields with on asterisk or not filled out entirely.

I understand that I can terminate dental coverage : • When terminating all other MBA group insurance coverage, or • As of March 31st

Employee Signature

Date

Email completed form to: enrollments@aldrichadvisors.com,

or mail to:

Aldrich Benefits, P.O. Box 5253.,Portland, OR 97208

Questions, call 503-716-9328, or 503-716-9329.