The Confederated Tribes of the
Warm Springs Reservation of Oregon

GROUP ENROLLMENT/CHANGE FORM

P.O. BOX 45018, FRESNO, CA 93718-5018
(800) 442-7247 FAX (559) 499-2464

☐ New Enrollment ☐ Name/Address Change ☐ Reinstatement ☐ Rehire
☐ Annual Enrollment ☐ Change Enrollment ☐ Decline Coverage ☐ Termination

(Shaded area for office use only)

PART 1 — EMPLOYEE INFORMATION

Confederated Tribes of Warm Springs					GROUP NUMBER H35	Tribal Affiliation: ☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian Contract Health Eligible: ☐Yes ☐No
EMPLOYEE LAST	FIRST	MI	SS#			EFFECTIVE DATE
ADDRESS STREET	CITY	STATE	ZIP CODE	HOME PHONE ( )		BIRTHDATE MO DAY YEAR
HIRE DATE	JOB TITLE		☐MALE ☐FEMALE	☐SINGLE ☐MARRIED	☐WIDOWED ☐DIVORCED	☐SEPARATED	DEPARTMENT
EMPLOYEE TERMINATION DATE	REASON					Department Code

PART 2 — DEPENDENT INFORMATION

DEPENDENT INFORMATION (List persons to be covered/terminated.): [1] Relationship Code (relationship to participant) SPO=Spouse SON=Son DAU=Daughter DEP=Other Dependent

Add/ Drop	Last Name	First Name	MI	**Social Security Number MANDATORY FOR SPOUSE ENROLLMENT	Birth Date	Gender (Circle)	Relationship	Tribal Affiliation	Contract Health Eligible	Disabled
A D						M F		☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian	Y N	Y N
A D						M F		☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian	Y N	Y N
A D						M F		☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian	Y N	Y N
A D						M F		☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian	Y N	Y N
A D						M F		☐Tribe Member ☐Married into the Tribe ☐Other Indian ☐Non-Indian	Y N	Y N

IF ADDING OR DROPPING DEPENDANT STATE REASON:

PART 3 — OTHER INSURANCE INFORMATION

ARE YOU OR ANY OF YOUR DEPENDENTS (INCLUDING SPOUSE) COVERED UNDER ANOTHER HEALTH PLAN OR MEDICARE? ☐YES ☐NO IF YES, PLEASE COMPLETE THIS SECTION. Check if additional form attached. ☐

Name of other policy holder	Birth Date	Social Security Number	[3] Rel. Code	Sponsoring Employer	Insurance Carrier or Medicare	Group Number	[4] Benefit Types	[5] Policy Types	Coverage Date(s)
									Begin / / End / /

PERSONS COVERED UNDER ABOVE POLICY:

3 **Relationship Code** (specify relation to participant): SPO=Spouse OTH=Other 4 **Benefit Type(s)**: **M**=Medical **D**=Dental **V**=Vision **Rx**=Prescription 5 **Policy Type(s)**: **IND**=Individual Policy **GRP**=Group Plan **HMO**=Health Maintenance Organization **MED**=Medicare

PART 4 — COVERAGE DECLINATION

To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;

HEALTH PLAN COVERAGE (CHECK IF DECLINED)

I decline coverage for:

☐ Myself ☐ Children
☐ Spouse ☐ Spouse and Children

REASON FOR DECLINING HEALTH COVERAGE (CHECK IF DECLINED)

☐ Covered by spouse's group coverage ☐ Medicare
☐ Spouse covered by employer's group medical coverage ☐ Other (explain) ____________________

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

____________________ ____________
If declining coverage for employee/dependent(s) please sign here. Date

PART 5 — DECLARATION

☐ I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan of my employer and authorized payroll deductions from my earnings (if any) required to cover my share of the premium. I confirm the above beneficiary information.

____________________ ____________
Employee's Signature Date

Other Insurance Questionnaire

Employee Name ____________________ **Member ID#** ____________________

Claim No. ____________________ **Incurred** ____________________

Account No. ____________________ **Group No.** ____________________

Do you or any of your covered dependents have other existing health coverage? Yes ________ No ________

If **no,** sign and date at the bottom and return this form to HealthComp.

If **yes,** please provide relevant information for each additional Carrier/Plan providing other health insurance coverage for you or your family below.

#1 Carrier/Plan Name: ____________________ Policyholder name: ____________________ DOB: ________

Plan Type (check one): __ Employer __Medicare Part: A B D (circle all that apply) __ Medicaid __ Individual __ Retiree __ Other __

Coverage type: __Medical __ Dental __Vision __RX (check all that apply) Effective Date: ________ Termination Date: __________ (if applicable)

#2 Carrier/Plan Name: ____________________ Policyholder name: ____________________ DOB: ________

Plan Type (check one): __ Employer __Medicare Part: A B D (circle all that apply) __Medicaid __ Individual __Retiree __Other______

Coverage type: __Medical __ Dental __Vision __RX (check all that apply) Effective Date: ________ Termination Date:__________ (if applicable)

Carrier #'s (see above)	Covered dependents	Relationship to policyholder	Is coverage court-ordered? (If yes, attach relevant pages)	Person with whom child primarily resides & their relationship to child
_____	__________________	__________	Yes____ No____	____________________
_____	__________________	__________	Yes____ No____	____________________
_____	__________________	__________	Yes____ No____	____________________
_____	__________________	__________	Yes____ No____	____________________
_____	__________________	__________	Yes____ No____	____________________

Please list the Name and Date of Birth for all covered dependents who do not have other health insurance:

Dependent name	DOB	Dependent name	DOB
__________________	__________	__________________	__________
__________________	__________	__________________	__________

I declare under penalty of perjury that the above statements are true and complete to the best of my knowledge.

Your Signature: ____ Date: ____________________