

# Individual Dental Policy Application



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Fax (541) 225-3646  
individual@pacificsource.com

Please write legibly in black or blue ink

## SECTION 1 – PLAN SELECTION

This application is (check one):

- For new coverage for myself and my eligible family member(s) listed below.
- To change my existing coverage in a PacificSource individual dental plan. Current policy ID # \_\_\_\_\_
- To add eligible family members to my existing PacificSource individual dental plan. Current policy ID # \_\_\_\_\_  
Reason for addition: \_\_\_\_\_ Date: \_\_\_\_\_
- For my dependent child(ren) only. Complete a separate form for each child on his or her own plan. If on a separate plan, dependent children age 18 or older must complete their own application.

Requested effective date (no more than 60 days after the signature date):  1<sup>st</sup>  15<sup>th</sup> \_\_\_\_\_ Month/Year

Will your employer pay any portion of your premium?  Yes  No *PacificSource individual policies may not be used for an employer-based plan. If the employer pays or reimburses any part of the premium or if the health plan is treated as part of a plan or program for the purposes of section 106 or 162 of the Internal Revenue Code of 1986. PacificSource does not accept premium payment from employers for individual policies.*

## SECTION 2 – APPLICANT INFORMATION

Last Name		First Name		Middle Initial
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Registered Domestic Partnership <input type="checkbox"/> Married <input type="checkbox"/> Unregistered Domestic Partnership* <i>* Affidavit of Domestic Partnership Required</i>		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (mo/day/year)	Social Security Number
E-mail Address			Home Phone	
Mailing Address (Street or PO box)		City	State	Zip
				County
Home Address (if different)		City	State	Zip
				County

List all family members to be insured. Only your legal spouse, domestic partner, and dependent children are eligible.

Last Name	First name, middle initial	Sex	Birth Date	Social Security No.
Spouse/Domestic Partner*				
Child				
Child				
Child				

Attach additional pages, if necessary.  I have attached \_\_\_\_\_ page(s).

Explain the relationship to you of any person listed above whose last name is different from yours. If spouse, attach copy of marriage certificate. If registered domestic partner, attach copy of certificate of domestic partnership. If guardian, attach copy of documentation: \_\_\_\_\_

\* Unregistered domestic partners must submit an Affidavit of Domestic Partnership with this application.

## SECTION 3 – OTHER INSURANCE INFORMATION

Do you or any family members have other active dental coverage?  Yes  No. If yes, provide insurance company's name in the box on the next page.

Do you or any family members work for an employer who offers dental benefits to employees?  Yes  No. Are you or any family members enrolled?  Yes  No. If no, why? \_\_\_\_\_

How did you hear about PacificSource?  Insurance Agent  Mailing  TV  Web site  Other \_\_\_\_\_

The policy's exclusion periods for specified conditions may be reduced if you or a family member had creditable coverage to within 63 days of the effective date of this policy. To reduce the exclusion periods, you must demonstrate creditable coverage. You may do that by attaching a Certificate of Coverage issued by the prior insurance company or group policyholder, or by presenting evidence of creditable coverage through other documents, records, third party statements, or other means. If you are currently covered under another dental policy, or are requesting credit toward the exclusion periods for prior coverage, please complete the following:

<b>List current or prior insurance coverage here:</b>		
Names of individuals covered under a current or prior policy:		
Name and address of other insurance company (include phone no. if available):		
Effective dates of coverage: From _____ To _____	Policy no.:	If group insurance, name of group policyholder:

**SECTION 4 – ACKNOWLEDGEMENT AND DECLARATION**

I acknowledge and understand that my dental or health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating dental or health care treatment or payment, or for business operations necessary to administer dental or 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 healthcare 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.*

I affirm that the answers given in this application are complete and correct. I understand and agree that no coverage will be in force unless, and until, a policy is issued. If approved, coverage will be in force as of the effective date determined by PacificSource.

_____ Applicant's Signature	_____ Date	_____ Spouse's/Domestic Partner's Signature	_____ Date
_____ Signature of child age 18 or over (if applying for coverage)	_____ Date	_____ Signature of child age 18 or over (if applying for coverage)	_____ Date

*Required if applicant is a minor:*

_____ Signature of (check one) <input type="checkbox"/> Parent <input type="checkbox"/> Guardian	_____ Date	_____ Printed Name of Parent or Guardian
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**This application must be signed and dated no more than 60 days prior to the requested effective date.**

**All fields must be completed for this authorization to be valid.**

**If approved, PacificSource will provide the policyholder with a copy of this completed form with the policy.**

**SECTION 5 – PRODUCER AUTHORIZATION**

I, the insurance producer, have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the policy except through written material furnished by PacificSource. The applicant has been informed that the effective date of coverage is assigned only by PacificSource. **I hereby certify that information supplied to me by the applicant has been truly and accurately recorded hereon.**

_____ Producer's Name (printed)	_____ PacificSource Producer Number
_____ Producer's Signature	_____ Date

<b>Office Use Only</b>