

Other Coverage

If you, your spouse/domestic partner or other dependents are covered by District coverage or by any other health care insurance, complete the following section:

Is your spouse/domestic partner also an employee of the School District?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you or any family member(s) covered by:	<input type="checkbox"/> Medicare <input type="checkbox"/> Other coverage If yes, check the types of coverage <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Complete the "Family Members With Other Coverage" section below.

Early Retiree Information

LAST NAME	FIRST	INITIAL	EMPLOYEE ID NO.
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Child Custody Information

If you or your spouse are divorced or legally separated, please indicate who has custody of your dependent child(ren)?	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Has the parent without custody been mandated by court decree to provide coverage for the dependent child(ren)?	<input type="checkbox"/> Yes If yes, complete the "Family Members With Other Coverage" section below. <input type="checkbox"/> No

Family Members With Other Coverage

To be completed only if you, or a dependent you are enrolling through the Trust, has other insurance.

NAME OF FAMILY MEMBER WITH OTHER COVERAGE	DATE OF BIRTH	NAME OF OTHER INSURANCE PLAN
NAME OF EMPLOYEE	GROUP ID NUMBER	EFFECTIVE DATE OF OTHER COVERAGE
CLAIMS ADDRESS		

Medicare Eligibility

Completion of this information is required.

Name	Enrolled in Medicare? (If Yes, provide a copy of your Medicare card with this form)		Check Box if Applicable	Date Dialysis Began or Date of Transplant (MM/DD/YY)
	Part A	Part B		
SELF	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Transplant	
SPOUSE/DOMESTIC PARTNER	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Transplant	
DEPENDENT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Transplant	
DEPENDENT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Transplant	
DEPENDENT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Transplant	

Signature

My signature below indicates that I have read and understand this enrollment form and descriptive materials provided. This enrollment form is binding on me and cannot be revoked or modified except as explained in the descriptive materials provided. I authorize my insurance carriers to obtain, examine, or release any medical or dental records or other information needed to coordinate benefits or process claims for me and my family members. I also authorize any provider having knowledge of my medical history or my dependents to release to my insurance carriers any medical information it requests. I authorize my insurance carriers to share such medical information with me or my dependents' health care providers. I declare that the dependents listed on this form are my eligible dependents and will be subject to verification of eligibility. I also declare that the information furnished on this form is correct and complete to the best of my knowledge.

SIGNATURE VERIFYING I'VE READ AND UNDERSTAND MATERIAL	DATE
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Return completed form to:
Trust Office, 700 NE Multnomah St., Suite 350, Portland, OR 97232
Phone: 1-503-238-6961 or 1-844-203-0239 (toll free), Option #2
Fax: 1-503-238-0205