TRUSTEED PLANS SERVICE CORPORATION

P.O. Box 1894
Tacoma, WA 98401-1894
(253) 564-5850
(800) 426-9786

Member Application/Change Form for Dental & Vision Coverage

I. EMPLOYER MUST COMPLETE THIS SECTION AND CHECK APPROPRIATE BOXES:

Group Name
Corvallis School District

Group Number
45830

Division/Department

☐ Hourly
☐ Salary

I hereby certify that all employment information specified above is accurate and complete:

______________________ ______
Employer Representative Date

Changes—Additions—Terminations

☐ New Employee
☐ Adding Dependent(s)
☐ Coverage Change
☐ Name Change
☐ Address Change
☐ Transfer to COBRA
Effective: ___________

☐ Terminate Coverage for:
☐ Subscriber
☐ Spouse
☐ Child(ren)

Reason for termination:
____

Employment Information:

Original Hire Date ________________
Date of Rehire ________________
P.T. to Full Time ________________
Hours Worked Per Week ________________
Open Enrollment ☐ Yes ☐ No
Late Enrollment ☐ Yes ☐ No
Special Enrollment ☐ Yes ☐ No

Effective Date ________________

II. EMPLOYEE MUST COMPLETE THE FOLLOWING : Marital Status: ☐ Married ☐ Single Date Married: ____________________

Subscriber Name (last, first): ____ Phone #: ________________

Address: ______________________________ City: ________________ State: _______ Zip: __________

If new employee, please list all covered dependents and check the add box. If change to existing eligibility, please check add or delete box and list dependent information.			Relationship	Sex	Birthdate (M/D/Y)	Social Security #
ADD	**DEL**	**LAST NAME FIRST NAME MI**				
☐	☐		Self	☐ Male ☐ Female	/ /	- -
☐	☐		Spouse	☐ Male ☐ Female	/ /	- -
☐	☐			☐ Male ☐ Female	/ /	- -
☐	☐			☐ Male ☐ Female	/ /	- -
☐	☐			☐ Male ☐ Female	/ /	- -
☐	☐			☐ Male ☐ Female	/ /	- -

STUDENT ELIGIBILITY/DISABLED CHILD: If you have listed a dependent child over the age of 18 years, please answer the questions below about your dependent:

Married? ☐ Yes ☐ No
Income tax dependent? ☐ Yes ☐ No
Resides regularly as a member of your household? ☐ Yes ☐ No
Developmentally/physically disabled? ☐ Yes ☐ No (Medical documentation must be submitted within 31 days of the effective date of coverage.)
Full-time student at an accredited school? ☐ Yes ☐ No List name of college, university, vocation school ______________________________

PRIOR/ADDITIONAL DENTAL BENEFITS INFORMATION:

Are you or any listed dependents above covered under another dental plan? ☐ Yes ☐ No Names: ______________________________

If yes, name of other insurance company: __________________________ Address __________________________ Phone ____________

Subscriber ID #: ____________________ Group Plan/Policy Number: ____________________ Effective Date of Coverage: ______________

By enrolling in this Plan you specifically authorize the Plan, TPSC, and their respective business associates to use personal information in their possession to administer the Plan (including the evaluation of eligibility under the Plan) and to detect or prevent fraud or misrepresentation, and to further disclose such information as is reasonably required for those purposes. You further authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or for detecting or preventing fraud or misrepresentation. You further waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of administering the Plan (including processing or evaluating a claim for benefits under the Plan) or to detect or prevent fraud or misrepresentation. This authorization does not and is not intended to in any way limit any right the Plan, TPSC, or their respective business associates may have under applicable state or federal law or regulation regarding the use of such information.

SUBSCRIBER SIGNATURE ________________________________ **DATE** ____________________

PLEASE COMPLETE THIS FORM IN FULL. ENROLLMENT IN THE PLAN WILL NOT BE PROCESSED IF THE APPLICATION IS RETURNED INCOMPLETE. THE SUBSCRIBER'S SIGNATURE AND DATE SIGNED MUST ALSO BE COMPLETED. Please notify TPSC in writing of any changes in your address or within 31 days of a change in status.