VIGILANT
benefits for employers

Vigilant Group Benefit Plans Enrollment Application/Change Form

Employer: Ochoco Lumber Company
1/1/2012

Please complete the appropriate items on both sides of this form

Type of Application (check one below)

- ❑ Open Enrollment -- Change to be effective January 1
- ❑ New enrollment. Date of regular full time hire: _____
- ❑ Waiving Medical Coverage. Sign separate Waiver Form.
- ❑ Recalled within six months of layoff: Date of recall: _____
- ❑ I am applying to add family members due to marriage or new Eligible Domestic Partner on: _____ (marriage certificate/DP certification/Affidavit of DP required)
- ❑ I am applying to add a newborn or adopted child, as listed below.
- ❑ I am applying to add family members because they lost other coverage on: _____

Reason coverage ended: _____ *Proof of Loss Required* Attached? ❑ Yes ❑ No

(check one below)

I am applying to remove family members from my coverage for the following reasons (Check one and list below the eligible person(s) that are to be covered):

- ❑ Voluntarily. (Effective 1st of month following signature date) _____
- ❑ Death. Date of death: _____
- ❑ Divorce/termination of Domestic Partnership. Date of final divorce decree/termination: _____
- ❑ Loss of dependent child status. Date and reason: _____ _____
- ❑ Other: _____

Applicant's Personal Information

Your Name: _____
Last First Middle Initial

Date of Birth _____ Social Security No_____ Phone # _____

Your Mailing Address: _____

Marital Status: ❑ Single ❑ Married ❑ Eligible Domestic Partner ❑ Divorced ❑ Separated

City, State, Zip: _____

Hours Worked Per Week _____

❑ Ochoco Lumber ❑ Ochoco Malheur ❑ Ochoco West

Pay Status: ❑ Salary ❑ Hourly

List Below All Persons to be Covered – Complete All Information for Each Person You Are Enrolling

Name	Gender	Social Security Number	Coverage	Date of Birth	Relationship to you
Employee _____ Last First Middle Initial	❑ M ❑ F	_____	❑ Medical	_____	*Self*
Sp/DP _____ Last First Middle Initial	❑ M ❑ F	_____	❑ Medical	_____	❑ Legal Spouse ❑ Eligible Domestic Partner
Child _____ Last First Middle Initial	❑ M ❑ F	_____	❑ Medical	_____	❑ Child ❑ Step-child ❑ Other _____
Child _____ Last First Middle Initial	❑ M ❑ F	_____	❑ Medical	_____	❑ Child ❑ Step-child ❑ Other _____
Child _____ Last First Middle Initial	❑ M ❑ F	_____	❑ Medical	_____	❑ Child ❑ Step-child ❑ Other _____
Child _____ Last First Middle Initial	❑ M ❑ F	_____	❑ Medical	_____	❑ Child ❑ Step-child ❑ Other _____

Employer Use Only: Effective Date: _____ Date Processed: _____ Processed By: _____ Notes: _____

Current/Prior Coverage Information

For EACH person listed on this application, you must list any health insurance coverage (including Medicare or Medicaid) in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect with the past 24 months, please indicate NONE.

MEDICARE. If you or any family members listed on this application have Medicare, is it ❑Part A ❑Part B ❑Part D. Complete the following information:

Enrolling Individual	Effective Date	Medicare Number (include alpha prefix)	Reason for Medicare Entitlement: ❑ Age ❑ Disability ❑ ESRD ❑ Dual Entitlement
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Applicant's Name (Non-Medicare)	Insurance Carrier Policy Number and Phone Number	Date of Coverage Month/Day/Year From	To	Will Coverage Continue?	Type of Coverage
1.				❑ Yes ❑ No	❑ Group ❑ Individual ❑ Medical ❑ Dental
2.				❑ Yes ❑ No	❑ Group ❑ Individual ❑ Medical ❑ Dental
3.				❑ Yes ❑ No	❑ Group ❑ Individual ❑ Medical ❑ Dental
4.				❑ Yes ❑ No	❑ Group ❑ Individual ❑ Medical ❑ Dental
5.				❑ Yes ❑ No	❑ Group ❑ Individual ❑ Medical ❑ Dental
6.				❑ Yes ❑ No	❑ Group ❑ Individual ❑ Medical ❑ Dental

Verification of Dependency

An eligible dependent includes children who are under the age of 26 who are your natural child, a stepchild, your adopted child or child placed for adoption or a child related to you by blood or marriage for whom you are the legal guardian. If you are enrolling a child for whom you have legal guardianship, you must submit a copy of the court document(s). *If additional information is required to determine the eligibility of the child, you will be notified.*

Child's Name	Is there a court order requiring you or your spouse to provide health insurance for this child? If yes, attach a copy of the Order
	❑ Yes ❑ No
	❑ Yes ❑ No
	❑ Yes ❑ No

TO ENROLL IN BENEFITS, READ AND SIGN THIS *AGREEMENT BELOW:*

I agree to the terms of this application as they appear in the following statement, which I have read carefully. I understand that benefits payable under this plan are limited to those described in the Summary Plan Description (SPD) booklet, and that I may not rely on information from any other source.

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating health-care treatment or 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: 1) a physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) a clinic, hospital, long-term care or other medical facility; 3) any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or; 4) 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 psychotherapy notes.

I understand that any newly eligible dependents may be enrolled during the Plan Year, provided application is made within the time allowed. I understand that eligible dependents not added at this time will be considered as waiving coverage and may only be added to my health coverage at the next open enrollment period, unless a change in life event occurs, in which case dependents must be added within the time allowed under the Special Enrollment provisions contained in the SPD.

To the best of my knowledge, the information I have given on this application is complete and true. I understand that my health plan may recover payments made, cancel my coverage, and refuse to pay claims if I have falsified information on this form.

This plan has a preexisting condition exclusion period which may be reduced by any prior creditable coverage you and/or your dependents may have had, as long as there was not a lapse in coverage of 63 days or more. The preexisting waiting period does not apply to any members under the age of 19.To reduce the exclusion period you must attach proof of prior creditable coverage (such as a Certificate Of Creditable Coverage (COCC) letter). Refer to the plan's SPD for details or check with your Employee Benefits Administrator.

TO ENROLL IN COVERAGE, SIGN AND DATE HERE:

Applicant's signature _____ Print Name _____ Date Signed _____