

MAILING ADDRESS

## 2023 Enrollment/Change of Status/Waiver Form

P.O. Box 4327, Portland, OR 97208-4327, 800-878-4445, **ProvidenceHealthPlan.com** 

Please complete all information on this form. This information is required to process your enrollment.

EMPLOYER GROUP NAME

GROUP NUMBER

DAT

// REQUESTED EFFECTIVE DATE	CLASS/SUBGROUP	START OF ELIGIBILITY WAITING PERIOD
New enrollment Open enrollme	nt Waiver of coverage SUBSCRIBER ID	NUMBER
Change in existing status:	**************************************	
	OR STATUS CHANGE* /ee, marriage, divorce, death, adoption, depend coverage, COBRA or state continuation.	DATE OF STATUS CHANGE EVENT lent change (add or drop), address/
COBRA/STATE CONTINUATION:/START DAT		
CHOSEN PLAN FOR ENROLLMENT:		
Total Enhanced Balance		Savings Account with HealthEquity® I to the HSA authorization form.
PLAN DEDUCTIBLE		
1. Employee Information		
FIRST NAME	LAST NAME	MI DATE OF BIRTH
SOCIAL SECURITY NUMBER	EMAIL	PHONE
GENDER (CHECK ONE) Male Fem	ale Non-binary/Other("U") MARITAL ST	TATUS: Married Single
HOW DO YOU IDENTIFY? Transgender (These fields are optional. Your responses	Male Transgender Female Non-biwill help us to better serve all communities.)	inary Decline to answer

PGC-OR 0123 SG ENROLL 8/2022 1 0F 4

CITY

STATE

ZIP

## 2. Dependent Information:\* (If waiving, see question 3)

Please include full, legal names.

1	LAST NAME FIRST NAM  Gender: M F Non-binary/Other  How do you identify? Transgender Male  (These fields are optional. Your responses	("U") Lives	<u> </u>	SOCIAL SECURITY # DATE OF  Y N If no, please include hord- binary Decline to answer  mmunities.)	
	DEPENDENT'S HOME ADDRESS			APARTMENT/UNIT NUMBER	
	CITY	STATE	ZIP	COUNTY	
2	LAST NAME  Gender: M F Non-binary/Other  How do you identify? Transgender Male  (These fields are optional. Your responses	("U") Lives		SOCIAL SECURITY # DATE OF Y N If no, please include hor- phinary Decline to answer mmunities.)	
	DEPENDENT'S HOME ADDRESS			APARTMENT/UNIT NUMBER	
	CITY	STATE	ZIP	COUNTY	
3	LAST NAME  Gender: M F Non-binary/Other  How do you identify? Transgender Male  (These fields are optional. Your responses  DEPENDENT'S HOME ADDRESS	("U") Lives	better serve all cor	SOCIAL SECURITY # DATE OF DATE OF N If no, please include hoto-binary Decline to answer mmunities.)  APARTMENT/UNIT NUMBER	
	CITY	STATE	ZIP	COUNTY	
4	LAST NAME  Gender: M F Non-binary/Other  How do you identify? Transgender Male  (These fields are optional. Your responses  DEPENDENT'S HOME ADDRESS	("U") Lives	better serve all cor	SOCIAL SECURITY # DATE OF  Y N If no, please include hor- binary Decline to answer mmunities.)  APARTMENT/UNIT NUMBER	
	CITY	STATE		COUNTY	

PGC-OR 0123 SG ENROLL 8/2022 2 0F 4

<sup>\*</sup>If you have additional family members to be enrolled, please include them on a separate sheet with this application.

3. Additional and/or Creditable Coverage. It is required to the coverage of the coverage of the coverage.			
Do you or your family members have additional grou	p health insurance an	d/or Medicare?	s No
If YES, check the type(s) of coverage:	Prescription Dru	ıg 🗌 Vision	
			_//_
NAME OF POLICYHOLDER		PO	LICYHOLDER'S DATE OF BIRT
			, ,
INSURANCE CARRIER	POLICY NUMBER		// EFFECTIVE DATE OF POLI
		l Na	
Have you had prior Providence Health Plan health co	verage? Yes	] NO	
If YES, please list previous member ID number:	ref coverage. It is required for payment of claims.)  ref have additional group health insurance and/or Medicare?   Yes   No  overage:   Medical   Prescription Drug   Vision    POLICYHOLDER'S DATE OF BIRTI		
4. Waiver of Coverage Information			
-	-		
	HEALTH PLAN NAME	POLICY NUMBER	EMPLOYER GROUP NAME
GROUP/MEDICARE)			
Notice: If you are declining enrollment for yourse	lf or vour dependents	including your snouse) b	ecause of other health
insurance coverage, you may, in the future, be abl	e to enroll yourself or	your dependents in this p	olan, provided that you
I understand that these communications will not i	include marketing, adv	vertising, or promotional	
<b>Accuracy of Enrollment Information:</b> Any person who an intent to knowingly defraud, files this application v			
materially false information or conceals material info	rmation, of Provid	lence Health Plan; (b) faci	ilitating health care
may be subject to criminal and civil penalties and Pro Health Plan may cancel such person's membership ar			
to pay their claims.			
<b>Payroll Deduction Authorization:</b> I authorize my emp to deduct the required contributions from my pay for	loyer authoriz		tione has provided a orginal
the coverage requested in this enrollment form. This	For more		
authorization applies to such coverage until I rescind writing. (Does not apply to COBRA, state continuation	n or to the No	tice of Privacy Practices	. A copy is available at
waiver of coverage.)	Provider	nceHealthPlan.com or by	calling Customer Service.
<b>Subscriber Acknowledgement:</b> I acknowledge and understand that Providence Health Plan may request	or SIGNATU	DE	
disclose health information, other than psychotherap	y notes,	N.C.	
about me or my dependents (persons who are listed f	DATE /		

PGC-OR 0123 SG ENROLL 8/2022 3 0F 4

## Race/Ethnicity Questionnaire The following questions are optional. Your responses will help us to better serve all communities.

MEMBER NAME		GROUP NAME	
Which of the following describe	s your racial or eth	nnic identity? Plea	ase check all that apply.
Hispanic and Latino/a/x	American		Black or African American
Hispanic and Latino/a/x  Hispanic or Latino/a/x Central American  Hispanic or Latino/a/x Mexican  Hispanic or Latino/a/x South American  Other Hispanic or Latino/a/x  Native Hawaiian or Pacific Islander  Guamanian or Chamorro  Marshallese  Communities of the Micronesian Region  Native Hawaiian  Samoan  Tongan  Other Pacific Islander  Other  I don't know.  I don't want to answer.	or Alaska N  America Alaska N  Canadian Nation Indigence Central A or South  White  Caucasia (no nation  Eastern  Western  Other Wi	n Indian lative In Indian lative In Inuit, Metis, or First Inus Mexican, American Inuit In	African American Afro-Caribbean Ethiopian
If you checked more than one ca or ethnic identity?	ategory above, is t	here one you thin	k of as your primary racial
Yes (please specify):			
No: I do not have just one primar identity.  No: I identify as Biracial or Multin		N/A: I don't ki	ecked one category above. now. ant to answer.
What is your preferred spoken la			
Spanish Viet Chinese - Other Rus	tonese namese sian man	French Tagalog Japanese Korean	Arabic Decline/Unknown Other
What is your preferred written l	anguage?		
English Viet	namese plified Chinese	Russian Other	N/A: I don't know. N/A: I don't want to answer.