2020 Enrollment/Change of Status/Waiver Form

PROVIDENCE Health Plan

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 _____ DATE OF HIRE __/__/__ REQUESTED EFFECTIVE DATE __/__/__

CLASS/SUBGROUP _____ ☐ New enrollment ☐ Open enrollment ☐ Waiver of coverage (see section 4) START OF ELIGIBILITY WAITING PERIOD __/__/__

SUBSCRIBER ID NUMBER _____ ☐ Change in existing status: _____ REASON FOR STATUS CHANGE* DATE OF STATUS CHANGE EVENT __/__/__

DEDUCTIBLE/COPAY _____ COBRA/STATE CONTINUATION: START DATE __/__/__ END DATE __/__/__

CHOSEN PLAN FOR ENROLLMENT: ☐ Option Advantage Base ☐ Option Advantage Plus (A) ☐ Option Advantage Premium (B) ☐ HSA ☐ Choice

☐ Integrated Health Savings Account with HealthEquity® I have read and agreed to the HSA Authorization form. ☐ Other: _____

1. Employee Information

FIRST NAME _____ LAST NAME _____ MI _____ DATE OF BIRTH __/__/__ SOCIAL SECURITY NUMBER _____

MARITAL STATUS: ☐ Married ☐ Single GENDER: ☐ Male ☐ Female PHONE _____ EMAIL _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

2. Dependent Enrollment Information (If waiving, see question 4.)

ADD	DROP	FIRST NAME	LAST NAME	MI	RELATION	SOCIAL SECURITY #	DATE OF BIRTH	GENDER
☐	☐							
☐	☐							
☐	☐							
☐	☐							
☐	☐							

Is the insurance of any dependents affected by divorce decree/court order? ☐ Yes ☐ No If YES, include portion of decree showing responsibility for medical expenses.

*Reasons include: rehired eligible employee, marriage, divorce, death, adoption, dependent change (add or drop), address or name change, involuntary loss of other coverage, COBRA or state continuation.

3. Additional and/or Creditable Coverage Information (This section is not a waiver of coverage. It is required for payment of claims.)

Do you or your family members have additional group health insurance and/or Medicare? ☐ Yes ☐ No

If YES, check the type(s) of coverage: ☐ Medical ☐ Prescription Drug ☐ Vision

NAME OF POLICYHOLDER

__ __/__ __/__ __
POLICYHOLDER'S DATE OF BIRTH

INSURANCE CARRIER

POLICY NUMBER

__ __/__ __/__ __
EFFECTIVE DATE OF POLICY

CARRIER PHONE NUMBER

FULL NAME(S) OF PERSONS COVERED

Have you had prior Providence Health Plan health coverage? ☐ Yes ☐ No If YES, please list previous member ID number:

4. Waiver of Coverage Information (Include the names of all eligible members who will NOT be enrolling with Providence Health Plan.)

PERSON(S) WAIVING COVERAGE	TYPE OF COVERAGE (INDIVIDUAL/EMPLOYER GROUP/MEDICARE)	HEALTH PLAN NAME	POLICY NUMBER	EMPLOYER GROUP NAME

Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

Communications: By signing this form, I authorize Providence Health Plan and its affiliates and vendors to communicate health plan information to me via text message and/or email, using my associated contact information provided on this form. I understand that these communications will not include marketing, advertising, or promotional material, and I may rescind this authorization at any time by submitting my request to Providence Health Plan.
☐ **I do not wish to receive e-mail or text messages from Providence Health Plan.**

Accuracy of Enrollment Information: Any person who, with an intent to knowingly defraud, files this application with materially false information or conceals material information, may be subject to criminal and civil penalties and Providence Health Plan may cancel such person's membership and refuse to pay their claims.

Payroll Deduction Authorization: I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing. (Does not apply to COBRA, state continuation or waiver of coverage.)

Subscriber Acknowledgement: I acknowledge and understand that Providence Health Plan may request or disclose health information, other than psychotherapy notes, about me or my dependents (persons who are listed for benefits coverage on the enrollment form) for the purpose of: (a) performing the health plan business operations of Providence Health Plan; (b) facilitating health care treatment; (c) issuing or facilitating payment for health care services; or (d) as required by law. The use or disclosure of psychotherapy notes by Providence Health Plan is restricted to circumstances in which the patient has provided a signed authorization.

For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available at **ProvidenceHealthPlan.com** or by calling customer service.

SIGNATURE

__ __/__ __/__ __
DATE