# Enrollment/Change of Status/Waiver Form

PROVIDENCE Health Plan

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

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

## Group information

Employer group name _____ Group number _____ Date of hire _____

Requested effective date _____ Class/subgroup _____

☐ New enrollment ☐ Open enrollment ☐ Waiver of coverage *(see section 4)*

☐ Change in existing status Reason for status change*_____ Date of event _____

Subscriber ID number _____ COBRA/state continuation: Start date _____ End date _____

Plan enrolling in: ☐ Core ☐ Open Option ☐ Personal Option ☐ Traditional Option

☐ HSA ☐ Integrated Health Savings Account with HealthEquity® – *I have read and agreed to the HSA authorization form.*

## Section 1 - Employee information

☐ Male ☐ Female Date of birth _____ Social Security number _____ ☐ Married ☐ Single

First name _____ Last name _____ Middle initial _____

Street address _____ City _____ State _____ ZIP _____

Mailing address *(if different than above)* _____ City _____ State _____ ZIP _____

Daytime phone _____ Evening phone _____ Email address _____

## Section 2 - Dependent enrollment information *(if waiving, see section 4)*

| Add | Drop | First name | Last name | Middle initial | Relationship to employee | Social Security number | Date of birth | Gender |
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*Enrollment reasons include: rehired eligible employee, marriage, domestic partner registration, divorce, death, adoption, dependent change (add or drop), address or name change, involuntary loss of other coverage, COBRA, or state continuation. (Dependents of Personal Option subscribers moving out of or back into the service area must use the Out-of-Area Dependent Enrollment Form. Contact customer service at the number listed above to obtain one.)



*(Continued on other side)*

## Section 3 - Additional and/or creditable coverage information *(This section is not a waiver of coverage. This information 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 types of coverage, then complete the information below: ☐ Medical ☐ Prescription drug ☐ Vision

Name of policyholder _____ Policyholder's date of birth _____

Insurance carrier _____ Policy number _____ Effective date of policy _____

Carrier phone number _____ Full names of persons covered _____

Is the insurance of any above dependents affected by a divorce decree / court order? ☐ YES ☐ NO

If YES, please include portion of decree that shows responsibility for medical expenses.

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

If you are applying for coverage within 63 days of termination of prior coverage, you may be eligible for credit toward any pre-existing condition limitation or exclusion period applicable under our plan.

Do you or any family members listed on this application have a Certificate of Creditable Coverage? ☐ YES ☐ NO

If **Yes**, please complete the Other Insurance Coverage information above and attach a copy of your Certificate of Creditable Coverage with this application.

## Section 4 - Waiver of coverage information *(Please include the names of all eligible members who will NOT be enrolling with Providence Health Plan.)*

| Person(s) waiving | Type of coverage (individual/employer group/Medicare) | Health plan name | Policy number | Employer group name |
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**Notice:** If you are declining enrollment for yourself or your dependents (including your spouse or registered domestic partner) 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, domestic partner registration, 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, domestic partner registration, birth, adoption or placement for adoption.

**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.

**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 **www.ProvidenceHealthPlan.com** or by calling customer service.

**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.)

Signature _____ Date _____