2024 Oregon Aglink Association Choice or Connect 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 __ __/__ __/__ __

COBRA: __ __/__ __/__ __ START DATE __ __/__ __/__ __ END DATE

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

CHOSEN PLAN FOR ENROLLMENT: ☐ Choice ☐ Connect _____ DEDUCTIBLE

As a Choice or Connect member, you will need to choose a medical home. A medical home selection form can be found on page 5.

1. Employee Information

FIRST NAME _____ LAST NAME _____ MI _____ DATE OF BIRTH __ __/__ __/__ __

PHONE _____ EMAIL _____ SOCIAL SECURITY NUMBER _____

MARITAL STATUS: ☐ Married ☐ Single GENDER: ☐ Male ☐ Female ☐ Non-binary/Other ("U")

HOW DO YOU IDENTIFY? ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ Decline to answer

(These fields are optional. Your responses will help us to better serve all communities.)

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

2a. In-Area Dependent Enrollment Information (If waiving, see question 4.)

ADD	DROP	FIRST NAME	LAST NAME	MI	RELATION	SOCIAL SECURITY #	DATE OF BIRTH	GENDER
☐	☐							M / F / U
		ADDRESS:		CITY:		STATE:	ZIP:	
		HOW DO YOU IDENTIFY?:	☐TRANSGENDER MALE	☐TRANSGENDER FEMALE	☐NON-BINARY	☐DECLINE TO ANSWER		
☐	☐							M / F / U
		ADDRESS:		CITY:		STATE:	ZIP:	
		HOW DO YOU IDENTIFY?:	☐TRANSGENDER MALE	☐TRANSGENDER FEMALE	☐NON-BINARY	☐DECLINE TO ANSWER		
☐	☐							M / F / U
		ADDRESS:		CITY:		STATE:	ZIP:	
		HOW DO YOU IDENTIFY?:	☐TRANSGENDER MALE	☐TRANSGENDER FEMALE	☐NON-BINARY	☐DECLINE TO ANSWER		
☐	☐							M / F / U
		ADDRESS:		CITY:		STATE:	ZIP:	
		HOW DO YOU IDENTIFY?:	☐TRANSGENDER MALE	☐TRANSGENDER FEMALE	☐NON-BINARY	☐DECLINE TO ANSWER		

If you have additional family members to be enrolled, please include them on a separate sheet with this application.

2b. Out-of-Area Dependent Enrollment Information (If waiving, see question 4.)

ADD	DROP	FIRST NAME	LAST NAME	MI	RELATION	SOCIAL SECURITY #	DATE OF BIRTH	GENDER
☐	☐							M / F / U
		ADDRESS:		CITY:		STATE:	ZIP:	
		HOW DO YOU IDENTIFY?:	☐TRANSGENDER MALE	☐TRANSGENDER FEMALE	☐NON-BINARY	☐DECLINE TO ANSWER		
☐	☐							M / F / U
		ADDRESS:		CITY:		STATE:	ZIP:	
		HOW DO YOU IDENTIFY?:	☐TRANSGENDER MALE	☐TRANSGENDER FEMALE	☐NON-BINARY	☐DECLINE TO ANSWER		
☐	☐							M / F / U
		ADDRESS:		CITY:		STATE:	ZIP:	
		HOW DO YOU IDENTIFY?:	☐TRANSGENDER MALE	☐TRANSGENDER FEMALE	☐NON-BINARY	☐DECLINE TO ANSWER		
☐	☐							M / F / U
		ADDRESS:		CITY:		STATE:	ZIP:	
		HOW DO YOU IDENTIFY?:	☐TRANSGENDER MALE	☐TRANSGENDER FEMALE	☐NON-BINARY	☐DECLINE TO ANSWER		

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 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, 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

Race/Ethnicity Questionnaire

The following questions will help us to better serve all communities. These questions are optional.

Which of the following describes your racial or ethnic identity? Please check all that apply.

Providence Health Plan

MEMBER NAME:

GROUP NAME:

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Hispanic or 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
- ☐ Native Hawaiian
- ☐ Communities of the Micronesian Region
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

White

- ☐ Caucasian/White (no national affiliation)
- ☐ Eastern European
- ☐ Western European
- ☐ Other White (African, Australian, New Zealand descent)
- ☐ Slavic

Black or African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Afro-Latinx/Bi-racial/Other
- ☐ Other Black

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Other

- ☐ Other
- ☐ Don't know
- ☐ Don't want to answer

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- ☐ **Yes** (please specify): _____
- ☐ **No:** I do not have just one primary racial or ethnic identity
- ☐ **No:** I identify as Biracial or Multiracial
- ☐ **N/A:** I only checked one category above.
- ☐ **N/A:** I don't know
- ☐ **N/A:** I don't want to answer

What is your preferred spoken language?

- ☐ English
- ☐ Spanish
- ☐ Chinese - Other
- ☐ Mandarin
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ German
- ☐ French
- ☐ Tagalog
- ☐ Japanese
- ☐ Korean
- ☐ Arabic
- ☐ Decline/Unknown
- ☐ Other

What is your preferred written language?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Simplified Chinese
- ☐ Russian
- ☐ Other
- ☐ **N/A:** I don't know
- ☐ **N/A:** I don't want to answer

Providence Medical Home Selection Form

About this form

Some health plans utilize a team of healthcare professionals led by a Primary Care Provider (PCP) at a designated clinic, referred to as a medical home, to provide and arrange care.

To maximize the benefits and value of your medical home plan, please designate a medical home provider for yourself and each enrolled dependent. You may choose the same or different medical homes for you and your enrolled dependents. **In the event a medical home is not chosen, one will be chosen for you.**

Medical home selections may be made through **myProvidence.org***, by calling customer service at **503-574-7500** or **800-878-4445 (TTY: 711)**, or by completing the sections below and returning this form via fax to **503-574-8208**, or by U.S. mail to:

Providence Health Plan
P.O. Box 4327
Portland, OR 97208

1. Subscriber Information

FIRST NAME _____ MI _____ LAST NAME _____

MEMBER ID NUMBER _____ GROUP NUMBER _____ PHONE _____ MEDICAL HOME _____

2. Dependent Information and Medical Home Selection

Please indicate member information and a medical home selection below. Refer to the provider directory available at **ProvidenceHealthPlan.com/ProviderDirectory** for medical home options. If you need more space, please use a separate page.

FIRST NAME	LAST NAME	MI	MEMBER ID #	MEDICAL HOME

Contact Information

For more information about your plan benefits and/or information about a specific medical home, please contact customer service at **503-574-7500** or **1-800-878-4445**, or **ProvidenceHealthPlan.com/ContactUs**.

*After enrollment and upon creation of a free myProvidence account.

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