Oregon Society of Certified Public Accountants (OSCPA) 2024 Enrollment Application/Waiver of Coverage

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 _____ REQUESTED EFFECTIVE DATE __ __ / __ __ / __ __ __ __

CLASS/SUBGROUP _____ GROUP NUMBER _____ DATE OF HIRE __ __ / __ __ / __ __ START OF ELIGIBILITY WAITING PERIOD __ __ / __ __ / __ __ __ __

ENROLLMENT DUE TO:

☐ New Group ☐ Open enrollment ☐ New Hire ☐ Adding Dependent(s) ☐ Removing Dependent(s)

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

*Reasons include: Rehired eligible employee, marriage, divorce, death, adoption, address or name change.

CHOSEN PLAN FOR ENROLLMENT:

☐ Opt Adv Plus 500 - Extend Network
☐ Opt Adv Plus 1000 - Extend Network
☐ Opt Adv Plus 2000 - Extend Network
☐ Opt Adv Plus 3000 - Extend Network
☐ Extend 3500 HSA
☐ Extend 5500 HSA
☐ Connect 500
☐ Connect 1000
☐ Connect 2000
☐ Connect 3000
☐ Connect 3500 HSA
☐ Connect 5500 HSA
☐ Choice 500
☐ Choice 1000
☐ Choice 2000
☐ Choice 3000
☐ Choice 3500 HSA
☐ Choice 5500 HSA
☐ Health Savings Account with HealthEquity®: I have read and agreed to the HSA Authorization form.

ELIGIBLE FOR COBRA DUE TO:

☐ Employment Termination or Reduced Hours ☐ Divorce or Legal Separation ☐ Death of Employee ☐ Dependent No Longer Meets Eligibility

__ __ / __ __ / __ __ __ __ COBRA/STATE CONTINUATION START DATE __ __ / __ __ / __ __ __ __ COBRA/STATE CONTINUATION END DATE

1. Employee Information

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

SOCIAL SECURITY NUMBER _____ PHONE _____ EMAIL _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

If you are declining coverage, skip to section 4.

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

ADD	DROP	FIRST NAME	LAST NAME	MI	RELATION	SOCIAL SECURITY #	DATE OF BIRTH	GENDER
☐	☐							M / F / U
☐	☐							M / F / U
☐	☐							M / F / U
☐	☐							M / F / U

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.

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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. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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

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.

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

Complete below only if choosing a Connect or Choice plan and return with enrollment form by mail or fax. You may also complete this information on your myProvidence Account.

Providence Health Plan

About this form

Some health plans utilize a team of health care professionals led by a primary care provider 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 **800-878-4445**, or **ProvidenceHealthPlan.com/ContactUs**

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