

# enrollment/change of status/waiver form

**PO Box 4327, Portland, OR 97208-4327, 1-800-878-4445, [www.providence.org/healthplans](http://www.providence.org/healthplans)**

Please complete all information on this form. The information you provide, including your e-mail address, will be used for Providence Health Plan business communication purposes only.

## Group information

Employer group name \_\_\_\_\_ Group # \_\_\_\_\_ 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 I.D. # \_\_\_\_\_ COBRA/state continuation: Start date \_\_\_\_\_ End date \_\_\_\_\_

**Plan enrolling in:**     **Open Option**     **Personal Option**     **HSA-Qualified**     **Traditional Option**

## Section 1 -

**Employee information**     Male     Female    Date of birth \_\_\_\_\_ Social Security No. \_\_\_\_\_     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 (\_\_\_\_) \_\_\_\_\_ E-mail address \_\_\_\_\_

## Section 2 -

### Dependent enrollment information (if waiving, see section 4)

Add	Drop	First name	Last name	Middle initial	Relationship to employee	Social Security No.	Date of birth	Gender
<input type="checkbox"/>	<input type="checkbox"/>							
<input type="checkbox"/>	<input type="checkbox"/>							
<input type="checkbox"/>	<input type="checkbox"/>							
<input type="checkbox"/>	<input type="checkbox"/>							
<input type="checkbox"/>	<input type="checkbox"/>							

\*Enrollment 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. (Dependents of Personal Option subscribers moving out of or back into the service area must use the Out-of-Area Dependent Enrollment Form. Contact your Customer Service team at the number above to obtain one.)

### Section 3 -

#### Additional 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 policy holder \_\_\_\_\_ Birthdate of policy holder \_\_\_\_\_

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# \_\_\_\_\_

### 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

**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.

**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 (PHP) may cancel such person's membership and refuse to pay their claims.

**Subscriber acknowledgement:** I acknowledge and understand that PHP 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 PHP; (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 PHP 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 our Internet site at [www.providence.org/healthplans](http://www.providence.org/healthplans) 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** \_\_\_\_\_



**for oregon small employer group use only**  
 to be used in conjunction with enrollment/change of status/waiver form.

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To be eligible for dental, disability or life insurance, offered by **Metropolitan Life Insurance Company New York, NY 10166-3690, 1-800-275-4638**, you must have medical coverage through Providence Health Plan. For dependent dental coverage, if offered by your employer, each dependent also must have medical coverage through Providence Health Plan or submit proof of other medical coverage in the waiver section of the accompanying Enrollment/Change of Status/Waiver Form

**I have received the MetLife Privacy Notice**

Member first name \_\_\_\_\_ Middle initial \_\_\_\_\_ Last name \_\_\_\_\_

<p><b>Dental Insurance</b></p> <p>I elect Dental for <input type="checkbox"/> myself <input type="checkbox"/> my dependents.</p> <p>I decline Dental for <input type="checkbox"/> myself <input type="checkbox"/> my dependents</p>	<p><b>Short Term Disability (STD) Insurance</b></p> <p><input type="checkbox"/> I elect STD</p> <p><input type="checkbox"/> I decline STD</p>	<p><b>Basic Life Insurance</b></p> <p>If contributory, <input type="checkbox"/> I elect Basic Life</p> <p><input type="checkbox"/> I decline Basic Life</p>
<p><b>Core Buy-Up Life Insurance:</b></p> <p><input type="checkbox"/> I elect Core (Basic) Life for myself.</p> <p><input type="checkbox"/> I decline Core (Basic) Life for myself</p> <p><input type="checkbox"/> I elect Buy-Up Life for myself: Amount: \$ _____</p> <p><input type="checkbox"/> I decline Buy-Up Life for myself</p> <p><input type="checkbox"/> I elect Buy-Up Life for my spouse: Amount: \$ _____ (Not to exceed 50% of Employee amount)</p> <p><input type="checkbox"/> I decline Buy-Up Life for my spouse</p> <p><input type="checkbox"/> I elect Buy-Up Life for my dependent child(ren): Amount: \$ _____</p> <p><input type="checkbox"/> I decline Buy-Up Life for my dependent child(ren)</p>		<p>If electing Buy-Up Life insurance: Have you or your dependents (if applicable) been hospitalized during the last 90 days preceding the date of this enrollment form?*</p> <p>Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dependent Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If Yes: a Statement of Health form (GEF02-1 MQ) is required.</p> <p><small>*Hospitalized means admission for inpatient care in a hospital, receipt of care in a hospice facility, intermediate care facility, or long term care facility, receipt of the following treatments wherever performed: chemotherapy, radiation therapy or dialysis.</small></p>

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**Employee Acknowledgement:** For purposes of medical coverage, I acknowledge and understand that PHP 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 PHP; (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 PHP 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 our Internet site at [www.providence.org/healthplans](http://www.providence.org/healthplans) 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.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_