Multnomah Bar Association Enrollment/Change of Status/Waiver Form

Mail Application to: Aldrich Benefits, P.O. Box 5253, Portland, OR 97208
Email to: Scarpentier@aldrichadvisors.com

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

IF YOU ARE AN ATTORNEY PROVIDE OSB # ____________

Group information

Law Firm Name______________________ Group number **MULTNOMAH BAR ASSOCIATION # 100218** Date of hire ____________

Requested effective date____________________ Eligibility waiting period start date:____________________ Hours worked per week ________

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 selection: GOLD PLAN ________ SILVER PLAN ________ H.S.A. PLAN ________

GOLD CONNECT PLAN____________ Connect plan requires that you designate a Providence clinic as your Medical Home must complete an additional 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

*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 customer service at the number listed above to obtain one.)

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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 ________________

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 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 ________________