2022 MBA Providence Enrollment Form

PROVIDENCE Health Plan

Mail form to: P.O. Box 5253, Portland, OR 97208 or Email form to: enrollments@aldrichadvisors.com

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

EMPLOYER GROUP NAME | GROUP NUMBER | DATE OF HIRE | ATTORNEY OSB # (IF APPLICABLE) | 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

DEDUCTIBLE/COPAY

COBRA/STATE CONTINUATION: START DATE | END DATE

PLAN SELECTION ☐ GOLD ☐ SILVER ☐ HSA E 3500 ☐ HSA 6650 ☐ EXTEND PPO NETWORK Check this box to enroll in the Providence Extend PPO network. Gold and Silver Plans only. (Higher premiums apply.)

1. Employee Information

FIRST NAME | LAST NAME | MI | DATE OF BIRTH | SOCIAL SECURITY NUMBER

MARITAL STATUS: ☐ Married ☐ Single GENDER: ☐ Male ☐ Female ☐ NON-BINARY OTHER ("U")

PHONE | EMAIL

MAILING ADDRESS | CITY | STATE | ZIP

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

ADD	DROP	FIRST NAME	LAST NAME	MI	RELATION	SOCIAL SECURITY #	DATE OF BIRTH	GENDER
☐	☐							
☐	☐							
☐	☐							
☐	☐							
☐	☐							

Is the insurance of any dependents affected by divorce decree/court order? ☐ Yes ☐ No If YES, include portion of decree showing responsibility for medical expenses.

*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.

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.

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: _____

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
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ 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/Biracial/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