

2026 Enrollment/Change of Status/Waiver Form



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 ____/____/____

DEDUCTIBLE _____

COBRA/STATE CONTINUATION: START DATE ____/____/____ END DATE ____/____/____

CHOSEN PLAN FOR ENROLLMENT: Option Advantage Base Option Advantage Plus Option Advantage Premium HSA Personal

ENROLL ME IN AN: Integrated Health Savings Account with HealthEquity® Other _____

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

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 _____

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

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

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.

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. 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
- Native Hawaiian

GROUP NAME:

- Communities of the Micronesia 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