Providence | Health Plan

ENROLLMENT / CHANGE OF STATUS FORM

PO Box 4327, Portland, OR 97208-4327
Portland: 503-574-7500 All other areas: 1-800-878-4445
TTY (For the Hearing Impaired): 503-574-8702 or 1-888-244-6642

Please check one:
☐ Personal Option ☐ $1,000 Deductible Open Option ☐ $250 Deductible Open Option

Please check one:
☐ To Enroll ☐ To change information regarding your membership

*Please complete **all** information on this form*

EMPLOYER NAME	DATE OF HIRE	EMPLOYER USE EFFECTIVE DATE:	PLAN USE GROUP NO.
Clackamas County			

EMPLOYEE'S FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY NO.	☐ Male ☐ Female	DATE OF BIRTH

HOME ADDRESS & APT. NO. AND MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP	HOME PHONE	BUSINESS PHONE	☐ Married ☐ Single

OTHER ENROLLMENT INFORMATION (This is not a waiver of coverage. This information is required for payment of claims.)

Do you or your family members have other group health insurance and/or Medicare? ☐ YES ☐ NO If yes, check the types of coverage: ☐ Medical ☐ Prescription Drug ☐ Vision

PLEASE ALSO COMPLETE THE FOLLOWING:	NAME OF POLICYHOLDER	BIRTHDATE OF POLICYHOLDER	INSURANCE CARRIER	POLICY NO.	CARRIER PHONE NO.

FIRST NAMES OF PERSONS COVERED

Is the insurance of any above dependents affected by a divorce decree / court order? ☐ NO ☐ YES – If Yes, please include portion of decree that shows responsibility for medical expenses.

PLAN USE	FULL, LEGAL FIRST NAME	FULL, LEGAL LAST NAME	FULL MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MO-DAY-YR)	WHAT IS RELATION TO SUBSCRIBER?	SEX	OUT-OF-AREA DEPENDENT?
SELF 1	Same as Above	Same as Above	Same as Above	Same as Above	Same as Above	Self		☐ Y ☐ N
SPOUSE 2					/ /			☐ Y ☐ N
CHILD 3					/ /			☐ Y ☐ N
CHILD 4					/ /			☐ Y ☐ N
CHILD 5					/ /			☐ Y ☐ N
CHILD 6					/ /			☐ Y ☐ N
CHILD 7					/ /			☐ Y ☐ N

PLEASE INDICATE THE REASON FOR COMPLETING THIS FORM

☐ NEW ENROLLMENT
☐ OUT OF AREA DEPENDENT RETURN TO SERVICE AREA
☐ ACTIVE ☐ COBRA Start Date_________ End Date________
☐ NAME OR ADDRESS CHANGE-
FORMER NAME ________________________________
☐ ADD DEPENDENT DUE TO – REASON: ________________
NAME(S):______________________________ DATE __________
☐ DELETE DEPENDENT – REASON: ____________________
NAME(S):______________________________ DATE __________

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding Psychotherapy Notes. A separate authorization will be used for this information.
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** or by calling Customer Service.

To the best of my knowledge, the above is correct and I understand that if I provide false information, the Health Plan can recover payment made, cancel my membership, and/or refuse to pay claims. In addition, I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

SIGNATURE____ DATE________________