2024 Enrollment / Change of Status / Waiver Form

P.O. Box 4327, Portland, OR 97208-4327, **800-878-4445**, **ProvidenceHealthPlan.com**

EMPLOYER GROUP NAME

GROUP NUMBER

CLASS/SUBGROUP

New enrollment Open enrollment Waiver of coverage
(see section 4)

SUBSCRIBER ID NUMBER

Change in existing status: REASON FOR STATUS CHANGE*

DEDUCTIBLE

START DATE

CHOSEN PLAN FOR ENROLLMENT:

Option Advantage Base Option Advantage Plus Option Advantage Premium HSA Personal

Integrated Health Savings Account with HealthEquity®
I have read and agreed to the HSA Authorization form.

Other

(If waiving, see question 4.)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in

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.

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.)

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

English	Cantonese	Fre01 s28901 0 Tdse check all that apply.
Spanish	Vietnamese	
Chinese - Other	Russian	
Mandarin	German	