2018 Oregon Application for Individual & Family Insurance

PROVIDENCE Health Plan

Thank you for choosing Providence Health Plan for your individual health insurance coverage.
You can compare plans, check rates and apply on our website at **ProvidenceHealthPlan.com**.

Please PRINT clearly in black or blue ink and mail or email your completed application and any necessary documentation to:
Providence Health Plan, P.O. Box 4649, Portland, OR 97208–4649

New PHP policyholders, email: **phpindapp@providence.org**. For questions, call: **503-574-5000** or **800-988-0088**.

Current PHP policyholders, email: **phpindividualforms@providence.org**. For questions, call: **503-574-5791**.

SEE PAGES 5 AND 6 FOR APPLICATION INSTRUCTIONS.

Step 1: Type of Application

1A: PLEASE SELECT ONE OF THE FOLLOWING BOXES DEPENDING ON YOUR PHP POLICYHOLDER STATUS

I am not a current Providence Health Plan Policyholder and I would like to:

☐ Submit a new application during Open Enrollment Nov. 1 – Dec. 15, 2017

☐ Submit a new application during Special Enrollment Jan. 1 – Dec. 31, 2018

(or) I am a current Providence Health Plan Policyholder and would like to:

☐ Make changes during Open Enrollment for the new 2018 benefit year [Nov. 1 – Dec. 15, 2017]

☐ Make changes during Special Enrollment after I or my family member has experienced a qualifying event

☐ Make changes or corrections to my policy information (i.e. name, address, tobacco usage), remove a dependent, or cancel my dental coverage

☐ Cancel my policy (Termination of your medical (and dental) coverage will be effective on the last day of the monthly period through which premium was paid at the time this form is received. Please refer to Step 1 in the Application Instructions for details including exceptions when reporting a death or retroactive enrollment in the Oregon Health Plan).

Current PHP subscriber ID number (located on your PHP ID card): _____ - _____

1B: THIS APPLICATION IS FOR (Please choose one)

☐ Myself Only: You must be at least 18 years old and reside in our service area.

☐ Myself and my spouse/domestic partner*: Includes you and your spouse or domestic partner. Both must reside in our service area.

☐ Myself and my children: Includes you, your dependent children age 25 and younger, and disabled dependents.

☐ Myself and my family: Includes you, your spouse or domestic partner, your dependent children age 25 and younger, and disabled dependents.

☐ Dependent only: Includes dependent age 20 and younger or disabled dependent. The responsible parent or legal guardian is the policyholder. Dependents must reside in our service area.

1C: SPECIAL ENROLLMENT QUALIFYING EVENT (If you have a qualifying event, please choose one)

If enrolling due to a special enrollment qualifying event, then please do so within 60 days of the special enrollment qualifying event.
Date of Event: _____/_____/_____

☐ Marriage or domestic partnership*

☐ Loss of coverage due to end of marriage or domestic partnership*

☐ Birth, adoption or placement for adoption or foster care of a child

☐ Acquired legal guardianship

☐ Loss of coverage as a dependent due to age

☐ Involuntary loss of coverage except for failure to pay the premium

☐ Qualified Medical Child Support Order (QMCSO)

☐ Relocation to the Providence Health Plan service area

☐ Loss/denial of or newly eligible for state premium assistance under a Medicaid or CHIP program

☐ No longer residing in your current plan service area

☐ Survivor of domestic abuse/violence or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner

☐ Loss of Advance Premium Tax Credit (APTC) or Cost Sharing Reductions (CSR), except for failure to pay the premium

EFFECTIVE DATE OF ENROLLMENT OR PLAN CHANGE(S)

The effective date of your new policy or change(s) to your existing policy will be determined based on the received date of your application as well as Providence Health Plan's receipt of premium. See page 5 of the Application Instructions for details including an exception for birth, adoption, or placement for adoption or foster care.

If you do not wish to receive a retroactive effective date for birth, adoption, or placement for adoption or foster care, or a prospective effective date of the 1st day of the following month; you may be eligible to select a future effective date. Applications are valid for up to 60 days from the signature date. If you are eligible and would like to receive a future effective date, please specify below.

Optional request for a future effective date: _____/ 01/ 2018 (must be within 60 days of the application signature date)

*A Domestic Partner must be a member of the applicant's same sex, 18 years of age or older and must have legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.

Step 2: Member Information

Please check one: ☐ New Application ☐ Change/Update ☐ Cancel Policy

2A POLICYHOLDER (age 18 and older)

Applicant/Policyholder Last Name | **First Name** | **MI** | **Date of Birth** (MM-DD-YYYY)

Home Address (No Post Office Box or retail/business addresses) | **City** | **State** | **Zip Code** | **County**

Mailing Address (if different from Home Address) | **City** | **State** | **Zip Code** | **County**

Email Address | **Home/cell Phone Number** (Required) | **Work Phone/Other Phone Number** (Optional)

Social Security Number | **Gender** (Check one) ☐ Male ☐ Female

Have you used any tobacco products an average of at least 4 times per week in the past 6 months? (Except for religious or ceremonial purposes)* ☐ Yes ☐ No

2B SPOUSE OR DOMESTIC PARTNER

Check one:
☐ Add ☐ Remove ☐ Change

Spouse/Domestic Partner Last Name | **First Name** | **Middle Initial**

Date of Birth (MM-DD-YYYY) | **Social Security Number** | **Gender** (Check one) ☐ Male ☐ Female

Have you used any tobacco products an average of at least 4 times per week in the past 6 months? (Except for religious or ceremonial purposes)* ☐ Yes ☐ No

2C ADDITIONAL FAMILY MEMBER(S)

(Please include full, legal names. For a dependent-only policy, dependent(s) must be age 20 and younger. For all other policies, dependents must be age 25 and younger.)

DEPENDENT CHILD #1

Check one: ☐ Add ☐ Remove ☐ Change

Dependent Child #1 Last Name | **First Name** | **Middle Initial** | **Gender** (Check one) ☐ Male ☐ Female

Date of Birth (MM-DD-YYYY) | **Social Security Number**

Have you used any tobacco products an average of at least 4 times per week in the past 6 months? (Except for religious or ceremonial purposes)* ☐ Yes ☐ No

DEPENDENT CHILD #2

Check one: ☐ Add ☐ Remove ☐ Change

Dependent Child #2 Last Name | **First Name** | **Middle Initial** | **Gender** (Check one) ☐ Male ☐ Female

Date of Birth (MM-DD-YYYY) | **Social Security Number**

Have you used any tobacco products an average of at least 4 times per week in the past 6 months? (Except for religious or ceremonial purposes)* ☐ Yes ☐ No

DEPENDENT CHILD #3

Check one: ☐ Add ☐ Remove ☐ Change

Dependent Child #3 Last Name | **First Name** | **Middle Initial** | **Gender** (Check one) ☐ Male ☐ Female

Date of Birth (MM-DD-YYYY) | **Social Security Number**

Have you used any tobacco products an average of at least 4 times per week in the past 6 months? (Except for religious or ceremonial purposes)* ☐ Yes ☐ No

Please explain your relationship to any person listed above whose last name is different from Policyholder

If you have additional family members to be enrolled, please include them on a separate sheet with this application.

* Tobacco use is defined as the use of tobacco products in any form an average of four or more times per week for the past six months. Regular tobacco users may pay a different premium.

2D ADDRESS INFORMATION FOR DEPENDENT(S) IN 2C ON A DEPENDENT-ONLY POLICY IF DIFFERENT FROM THE POLICYHOLDER IN 2A

(If your dependent child(ren) have more than one different address, please attach on a separate sheet)

Dependent child's name

Dependent's home address (Complete only if different from Policyholder)	**City**	**State**	**Zip Code**	**County**
Dependent's mailing address (Complete only if different from Policyholder)	**City**	**State**	**Zip Code**	**County**

2E BILLING ADDRESS IF DIFFERENT FROM THE POLICYHOLDER IN 2A

(Complete this section only if billing information should be sent to an address or person other than the Policyholder)

Full name | **Relationship to Policyholder or Dependent (required)**

Billing address	**City**	**State**	**Zip Code**

Step 3: Choose a Benefit Plan

Plan name (Check one)	**Network**	**Selling Areas**
☐ Connect 2500 Silver	Connect	Clackamas,Hood River, Multnomah, Washington, Yamhill (Newberg: 97132).
☐ Connect 7350 Bronze		
☐ Providence Standard Gold Choice	Choice	Benton, Clackamas, Clatsop, Crook, Deschutes, Douglas, Hood River, Jackson, Jefferson, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Washington, Yamhill.
☐ Providence Standard Silver Choice		
☐ Providence Standard Bronze HSA Choice		
☐ Providence Standard Gold Signature	Signature	Baker, Columbia, Coos, Curry, Gilliam, Grant, Harney, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler.
☐ Providence Standard Silver Signature		
☐ Providence Standard Bronze HSA Signature		
Dental Plan		
☐ Providence Progressive Dental	Must enroll in Medical plan	All counties in Oregon.

[Connect plans are available only in Clackamas, Hood River, Multnomah and Washington counties and in zip code 97132 in Yamhill county. The network for Standard plans varies. Please visit ProvidenceHealthPlan.com for details.]

* If you select a Connect or Standard Choice Network plan, you will need to choose a medical home and a primary care provider upon enrollment. To see medical homes in your area, view our provider directory at **ProvidenceHealthPlan.com/findaprovider**.

To review a summary of benefits and coverage (SBC) for these medical plans, visit **ProvidenceHealthPlan.com/sbc.** For more details on the Providence Progressive Dental plan, visit **ProvidenceHealthPlan.com**.

Providence Progressive Dental Plan: If you choose a medical plan and also progressive dental coverage, all people on the policy will be enrolled in the dental plan. There is a separate premium for the dental plan which will apply to each person on the policy. For children age 18 and younger who are enrolled on the Connect plans, this coverage will be supplemental to the pediatric dental coverage already included under the medical plan.

Pediatric Dental Disclaimer: Our Standard medical plans DO NOT include pediatric dental coverage. Under the health care reform law (the Affordable Care Act or ACA), if you purchase one of these plans outside of the Marketplace, we must have reasonable assurance that you have obtained separate pediatric dental coverage through a Marketplace-certified pediatric dental plan. This requirement applies whether you obtain coverage for children or adults. Marketplace-certified pediatric dental plans can be found through the Federal Health Insurance Marketplace at **HealthCare.gov**.

If you are a current policyholder and would like to cancel your dental coverage during the plan year, choose your current Medical Plan without the Providence Progressive Dental Plan option.

For more information on choosing the Providence Progressive Dental plan, see page 6 of the application instructions.

Step 4: Please Read, Sign & Submit

CERTIFICATION

Certification of Completion and Correctness

I affirm that the answers given in this Application for Coverage are complete and correct. I am providing these answers a part of the application procedure required by Providence Health Plan (PHP) to enroll for insurance coverage. I understand that if this application contains any intentional material misstatements or omissions, other than misstatements or omissions related to the use of tobacco products, PHP may rescind, modify or cancel the contract, and/or take any other legal action available to it by law. I will promptly inform PHP in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until the effective date determined by PHP and that PHP may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

I understand that I can visit **www.ProvidenceHealthPlan.com** to educate myself about PHP's privacy practices. I understand that I can get a copy of PHP's Notice of Privacy Practices by going to **www.ProvidenceHealthPlan.com** and selecting "Notice of Privacy Practice" or by calling Customer Service at 503-574-7500.

SIGNATURE

1. I understand that Providence Health Plan will:
   a. Send me an offer of coverage.
   b. Send me a legal contract after my policy has been effectuated.
2. I am the parent or legal guardian of any dependent child listed on this application.
3. I verify that my employer will not be paying the premium on this policy except as permitted by state or federal regulation.
4. I verify that the home address I provided on this application is my permanent residence and I intend to reside at this address.
5. I verify that I am not enrolled in Medicare. (The federal government does not allow health plans to issue Individual coverage that duplicates coverage available through Medicare.)
6. I understand that I must update my information with Providence Health Plan if anything changes (and is different than) what I wrote on this application.
7. I affirm that if I choose a medical plan without pediatric dental coverage, I will obtain pediatric dental coverage through a separate Marketplace-certified pediatric dental plan, and that I will notify Providence Health Plan if I do not obtain coverage.

By signing, I agree to the above conditions.

Signature of Policyholder, Legal Guardian or Power of Attorney (A copy of legal guardianship or power of attorney must accompany this form if not signed by the policyholder.)

Relationship to dependent under 18

Date

Please PRINT name

☐ **Signed by applicant for spouse or domestic partner***

Signature of Spouse or Domestic Partner*

* The applicant may sign for a spouse or domestic partner. Please check the appropriate box above.

FOR AGENT USE ONLY

(All fields are required)

I, (the agent) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Providence Health Plan.

I have informed the applicant that the effective date of coverage is assigned only by Providence Health Plan and provided the Oregon Disclosure Information required. I certify that the information supplied to me by the applicant has been truly and accurately recorded here.

Agent Name

Agency Name

PHP Agent Number (required)

Agent E-mail

Phone Number

Agent Signature

Date

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

Application Instructions

Please note: This form does not apply to plans purchased through the Federal Health Insurance Marketplace. Contact the marketplace at **www.HealthCare.gov** or call **1-800-318-2596**.

Please PRINT clearly in black or blue ink and mail or email your completed application and any necessary documentation to:
Providence Health Plan, P.O. Box 4649, Portland, OR 97208–4649

Applications for new members, email: **phpindapp@providence.org**

Current PHP members, email: **phpindividualforms@providence.org**

If you are a new member and need assistance, please contact your insurance producer or call the Providence Health Plan Sales Team at **503-574-5000** or **1-800-988-0088**, TTY: **711**. If you are an existing member and need assistance, please contact our Enrollment Member Service team at **503-574-5791** or **1-888-816-1300**.

You will be sent an offer of coverage with the following information: confirmation of plan chosen; list of covered family members; the amount and date of your first premium payment; and your effective date. You may pay your initial premium by personal check or debit/credit card (Visa or MasterCard only). Your initial premium payment must be received by the effective date or the date printed on your offer letter. Your offer letter is your initial invoice.

Do not send a payment with this application.

If your application is incomplete or additional information is required, your effective date may be delayed. Your application will expire 60 days after your signature date. Providence Health Plan will move your requested effective date forward to the next available date if your application has not expired.

Please note: All plans purchased using this application will expire Dec. 31, 2018.

Glossary of terms: Visit **ProvidenceHealthPlan.com/glossary** for a listing of health insurance terms and definitions.

STEP 1: TYPE OF APPLICATION

This section must be completed for all applications, changes, and policy cancellations.

Open Enrollment: Open enrollment for the 2018 benefit plan year is currently scheduled for November 1, 2017, through December 15, 2017. **Upon receipt of the initial Premium, the Effective Date of Coverage will be January 1, 2018**.

Special Enrollment: Providence Health Plan will accept applications for coverage outside of Open Enrollment if the applicant has experienced a Qualifying Event. To obtain coverage due to a Special Enrollment Qualifying Event, you must submit an application for coverage to Providence Health Plan within 60 days of the Qualifying Event.

The Effective Date of Coverage is determined by the Qualifying Event as well as Providence Health Plan's receipt of the initial Premium.

Date application is received	Coverage effective date	Date initial payment must be received by Providence
1st–15th of the month	1st day of the following month	1st day of the following month
16th–last day of the month	1st day of the 2nd following month	1st day of the 2nd following month

*When the Qualifying Event is birth, adoption, or placement for adoption or foster care; coverage will be effective from date of birth, adoption, or placement for adoption or foster care, provided the initial Premium is received within 14 days from the offer letter.

Optional Request for a Future Effective Date: If you do not wish to receive a retroactive effective date for birth, adoption, or placement for adoption or foster care, or a prospective effective date of the 1st day of the following month; you may be eligible to select a future effective date.

Applications are valid for up to 60 days from the signature date. If you are eligible and would like to receive a future effective date, please specify the date on the application.

Current PHP policyholder wishing to cancel your medical (and dental) policy: Termination of your medical (and dental) coverage will be effective on the last day of the monthly period through which premium was paid at the time this form is received. When reporting a death, please include a copy of the death certificate. Once documentation of death is received, PHP will retroactively terminate the policy. The effective date of termination will be the last day of the month following the date of death. PHP understands that enrollment in the Oregon Health Plan (OHP) is frequently granted on a retroactive basis. If you are canceling your policy because you or a family member is now effective on OHP, please clearly write this information along with your OHP effective date on your application form.

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STEP 2: MEMBER INFORMATION

This section must be completed for all applications, changes, and policy cancellations.

The policyholder home address is your physical permanent residence where you intend to reside. If you do not want to receive mail at this address, you can select a different mailing address and/or billing address. The individual identified in section 2E (Billing Address) will only receive premium invoices. All other correspondence will be mailed to the policyholder's home or mailing address.

Complete box 2D if your dependents on a dependent-only policy have a different home address (physical permanent residence where your dependent intends to reside) than you the policyholder.

STEP 3: CHOOSE A BENEFIT PLAN

If you are applying during Open Enrollment or have experienced a Special Enrollment Period Qualifying event, choose the Medical Plan option or Medical and Dental Plan option you would like that is available in your service area.

If you would like to cancel your current dental coverage, choose your current Medical Plan without the Providence Progressive Dental Plan option.

To review a summary of benefits and coverage (SBC) for these medical plans, visit **ProvidenceHealthPlan.com/sbc**.
For more details on the Providence Progressive Dental plan, visit **ProvidenceHealthPlan.com**.

Connect plans are available only in Clackamas, Hood River, Multnomah and Washington counties and in zip code 97132 in Yamhill county. The network for Standard plans varies. Please visit ProvidenceHealthPlan.com for details.

Important information about Dental coverage: In order to purchase the Providence Progressive Dental Plan, you must also purchase a PHP medical plan. If you choose the Providence Progressive dental plan, all people on the policy will be enrolled. There is a separate premium for the dental plan which will apply to each person on the policy. For children age 18 and younger who are enrolled on the HSA and Connect plans; this coverage will be supplemental to the pediatric dental coverage already included under the medical plan.

Our Standard medical plans DO NOT include pediatric dental coverage. Under the health care reform law (the Affordable Care Act or ACA), if you purchase one of these plans outside of the Marketplace, we must have reasonable assurance that you have obtained separate pediatric dental coverage through a Marketplace-certified pediatric dental plan. This requirement applies whether you obtain coverage for children or adults. Marketplace-certified pediatric dental plans can be found through the Federal Health Insurance Marketplace at **HealthCare.gov**.

Important information about Connect and Standard Choice Network plans: If you select a Connect or Standard Choice Network plan, you will need to choose a medical home and a primary care provider after your policy has been effectuated. To see medical homes in your area, view our provider directory at **ProvidenceHealthPlan.com/findaprovider**.

STEP 4: PLEASE READ, SIGN & SUBMIT

This section must be completed for all applications, changes, and policy cancellations.

PHP will not accept any postdated application forms.

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Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603- 2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

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Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)