PROVIDENCE
Health Plan

2019 Oregon Application for Individual & Family Insurance

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

THIS FORM IS FOR NEW ENROLLMENT ONLY

If you are a current Providence Health Plan Individual & Family Plan Policyholder, do not use this form.
To make changes to your account, please complete a 2019 Individual & Family Plan Change Form located on our website at **ProvidenceHealthPlan.com**.

This form cannot be used for Marketplace coverage in 2019. Please contact the Health Insurance Marketplace at **800-318-2596** or access your account online at **HealthCare.gov**.

SEE PAGE 7 FOR APPLICATION INSTRUCTIONS

STEP 1 – Type of Application

Applicant/Policyholder Name (please print):____

1A: PLEASE SELECT ONE OF THE FOLLOWING ENROLLMENT OPTIONS

☐ **I am enrolling for new coverage during OPEN ENROLLMENT 11/1/18 – 12/15/18.**
PHP must receive your completed application no later than 12/15/18. Your effective date will be 1/1/19 upon timely receipt of your initial premium payment.

☐ **I am enrolling for new coverage during a SPECIAL ENROLLMENT PERIOD 1/1/19 – 12/31/19.**
PHP must receive your completed application and required documentation within 60 days of the special enrollment qualifying event. The effective date of your new plan will be determined based on the type of Qualifying Event, the received date of your completed application and receipt of your initial premium payment.

Date of Qualifying Event _ _ / _ _ / _ _

Please Select Your Qualifying Event:

- ☐ Marriage or domestic partnership*
- ☐ Loss of coverage due to end of marriage or domestic partnership*
- ☐ Birth, adoption or placement for adoption of a child
- ☐ Placement of a child for foster care
- ☐ Acquired legal guardianship
- ☐ Loss of coverage as a dependent due to age
- ☐ Permanent move to a new PHP service area that offers different health plan options
- ☐ Involuntary loss of coverage except for failure to pay the premium
- ☐ Qualified Medical Child Support Order (QMCSO)
- ☐ Loss/denial of, or newly eligible, for state premium assistance under a Medicaid or CHIP program
- ☐ 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)

*A Domestic Partner must be a member of the Policyholder'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

2A: THIS APPLICATION IS FOR (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. You, the Policyholder, must reside in our service area.

☐ **Myself and my family:** Includes you, your spouse or domestic partner,* your dependent children age 25 and younger, and disabled dependents. Both you and your spouse/domestic partner must reside in our service area.

☐ **Child only:** Includes dependent children age 20 and younger. The responsible parent or legal guardian is the Policyholder. All enrolled dependent children must reside in our service area.

*A Domestic Partner must be a member of the Policyholder'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.

2B: APPLICANT / POLICYHOLDER INFORMATION

The Policyholder must be 18 years of age or older. The Policyholder is financially responsible for the account and is the person who is authorized to make changes to the plan.

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

Sex (check one) ☐ Male ☐ Female

Have you used any tobacco products in the last 6 months? ☐ Yes ☐ No

Tobacco use is defined as an average of at least 4 times per week, except for religious or ceremonial purposes.

Step 2 – Member Information (continued)

2C: DEPENDENT INFORMATION

Please include full, legal names. For a child-only plan, children must be age 20 and younger as of their effective date. For all other plans, children must be age 25 and younger as of their effective date.

Note: If any dependents do not reside at the Policyholder's home address, you must complete Section 2D below.

Last Name	First Name, MI	Relationship to Subscriber	Sex	Date of Birth	Social Security Number
		☐ Spouse ☐ Domestic Partner	☐ F ☐ M	_ _ / _ _ / _ _	
Does this dependent live at the Policyholder's home address? ☐ Yes ☐ No Does this dependent use tobacco products?* ☐ Yes ☐ No					
			☐ F ☐ M	_ _ / _ _ / _ _	
Does this dependent live at the Policyholder's home address? ☐ Yes ☐ No Does this dependent use tobacco products?* ☐ Yes ☐ No					
			☐ F ☐ M	_ _ / _ _ / _ _	
Does this dependent live at the Policyholder's home address? ☐ Yes ☐ No Does this dependent use tobacco products?* ☐ Yes ☐ No					
			☐ F ☐ M	_ _ / _ _ / _ _	
Does this dependent live at the Policyholder's home address? ☐ Yes ☐ No Does this dependent use tobacco products?* ☐ Yes ☐ No					

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

*Tobacco use is defined as an average of at least 4 times per week, except for religious or ceremonial purposes.

2D: DEPENDENT HOME ADDRESS(ES) IF DIFFERENT FROM THE POLICYHOLDER

Dependent's Name

Dependent's Home Address **City** **State** **Zip Code** **County**

Dependent's Name

Dependent's Home Address **City** **State** **Zip Code** **County**

Step 3 – Choose a Benefit Plan

Medical Plan (Check one)	**Network**	**Selling Areas**
☐ Connect 2500 Silver	Connect	Clackamas, Hood River, Multnomah, Washington, Yamhill (Newberg zip code 97132 only)
☐ Connect 7900 Bronze		
☐ Providence Oregon Standard Gold - Choice	Choice	Benton, Clackamas, Clatsop, Crook, Deschutes, Douglas, Hood River, Jackson, Jefferson, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Washington, Yamhill
☐ Providence Oregon Standard Silver - Choice		
☐ Providence Oregon Standard Bronze - Choice		
☐ HSA Qualified 6650 Bronze - Choice		
☐ Providence Oregon Standard Gold - Signature	Signature	Baker, Columbia, Coos, Curry, Gilliam, Grant, Harney, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler
☐ Providence Oregon Standard Silver - Signature		
☐ Providence Oregon Standard Bronze - Signature		
☐ HSA Qualified 6650 Bronze - Signature		
Dental Plan (Optional)		
☐ Providence Progressive Dental	Must enroll in medical plan	All counties in Oregon

To review a Summary of Benefits and Coverage (SBC) for these medical plans, visit **ProvidenceHealthPlan.com/sbc**.

If you select a Connect or 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**.

Providence Progressive Dental Plan: 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 plan 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 Connect plans, this coverage will be supplemental to the pediatric dental coverage already included under the medical plan.

Pediatric Dental Disclaimer: Our Standard and HSA 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**.

For more details on the Providence Progressive Dental plan, visit **ProvidenceHealthPlan.com**.

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 as 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 **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 **ProvidenceHealthPlan.com** and selecting "Notice of Privacy Practice" or by calling Customer Service at **503-574-7500**.

SIGNATURE

1. I understand that this is an individual health insurance contract and I verify that neither my employer nor any third party will be paying the premium on this policy except as permitted by state or federal regulation.
2. 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.)
3. I am the parent or legal guardian of all dependent children listed on this application.
4. I verify that the home address I provided on this application for myself is accurate, as well as any other address provided by me for any dependents included on this application.
5. 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.
6. 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.
7. I understand that:
   a. Providence Health Plan will send me an offer of coverage, containing terms for initial premium payment.
   b. I need to pay my initial premium payment by the due date specified on my offer of coverage to effectuate my policy.
   c. After my policy has been effectuated, Providence Health Plan will send me a legal contract.
8. I understand that this application does not terminate other coverage through the Federal Marketplace, Providence Health Plan or other carriers.

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.)

Date (required)

Please PRINT Name

Signature of Spouse or Domestic Partner

☐ **Signed by Policyholder Applicant for Spouse or Domestic Partner**

The Policyholder 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**

Application Instructions for Individual or Family Coverage

Who is eligible?

You may use this form to apply for **NEW** Individual or Family coverage from Providence Health Plan.

To be eligible for Providence Health Plan coverage:

- You must live in our Oregon service area.
- You cannot be entitled to Medicare Part A or enrolled in Medicare Part B.

If you would like coverage for your entire family on the same plan, fill out one application for the entire family. A separate application is required for family members who would like coverage on a different plan.

Federal financial assistance may be available to help pay your premiums. To determine if you qualify, you must apply for coverage through the Health Insurance Marketplace at **HealthCare.gov**.

How to apply

- You may apply online by visiting **ProvidenceHealthPlan.com**. Child-only plans or families who need to list more than 3 children require a paper application.
- Applications received with Qualifying Events will be given an effective date according to the following table. For further instructions and details related to a Special Enrollment Period (SEP), visit **ProvidenceHealthPlan.com**.

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

- This application does NOT cancel any other coverage. To avoid paying two premiums or having overlapping coverage, you need to take action to terminate any other plans that may currently be active.
- If your application is incomplete, lacks a signature or signature date, or if additional information is required, your effective date may be delayed. Your application will expire 60 days after the signature date. PHP will not accept any postdated applications.
- Send your completed application to:

  Providence Health Plan
  P.O. Box 4649
  Portland, OR 97208-4649

  -OR- Email to: **phpindapp@providence.org**
- **Providence Health Plan will bill you for your initial premium.**
- All plans purchased using this application will expire December 31, 2019. All plans guaranteed renewable for the next plan year.
- Providence Health Plan recommends you keep a copy of your completed application for your records.

Need help?

- For a glossary of terms, visit **ProvidenceHealthPlan.com/glossary** for a listing of health insurance terms and definitions.
- If you need assistance completing your application, contact your Insurance Producer or call the Providence Health Plan Sales team at **503-574-5000** or **1-800-988-0088**, **TTY: 711**.

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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 می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-800-878-4445 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)

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