Providence Health Plan

Oregon Small Group Enrollment Checklist for Producers 2024 Contract Year

In order to provide excellent service to our members, Providence Health Plan has a deadline for new small group enrollments. For new group submissions, a clean and complete set of materials must be received in our office by the 20th of the month prior to the desired effective date if not submitted via Wired Enroll, or by the 25th if submitted via Wired Enroll.

Wired Quote/Wired Enroll is the fastest, most secure way to submit your new small group to Providence. Wired Quote/ Wired Enroll are available to Providence appointed producers at no cost. Using Wired Quote/Wired Enroll ensures the completeness and accuracy of your new small group submission and helps Providence to speed up processing time, resulting in a better experience for your group. You can find additional information about getting a small group quote, including how to access Wired Quote and Wired Enroll on the Get a Quote page on our website.

Small Group Submission Checklist

Prior to submission, please review all new group enrollment materials for accuracy and completeness. Incomplete enrollment materials will be returned to the Producer for completion, and will delay the group's enrollment. The following checklist is a helpful reference of what is required for each submission.

Master Contract Application

- ❑ Verify you are using the current Oregon Master Contract Application
- ❑ Group name, physical address, and county
  - ○ If the group name is different than the DBA, indicate both; if the address on the check is different than on the Master Contract Application, indicate why
- ❑ NAICS Code
- ❑ Effective date
- ❑ Business Federal Tax ID# (10 digits)
- ❑ CMS group size
- ❑ Subject to COBRA or State Continuation indicated
- ❑ Minimum hours
- ❑ Number of Benefit Eligible Employees
- ❑ Probationary period
- ❑ Waiving probationary period at initial enrollment
- ❑ Previous carrier (mark N/A if none)
- ❑ Products selected
- ❑ Producer name and signature
- ❑ Authorized group signature

  Remember: If group materials are submitted without a check for first month's premium, group will be invoiced upon enrollment. *Note:* New group approval will be contingent upon payment received and posted.

Group Size Determination Form (GSD)

- ❑ Authorized producer name or group signature (back page)
- ❑ Questions to determine group size and eligibility
- ❑ Employee and eligible employee count

  Note: Be sure to read the explanatory text on the first page before calculating FTEs. A link is provided to the federal FTE calculator.

Enrollment/Change of Status/Waiver Forms or Enrollment Spreadsheet - Quoted census from Wired Quote can be transferred directly into spreadsheet enrollment -- see instructions in Wired Quote. This is not the same as Wired Enroll and submitting a spreadsheet enrollment in this format will not earn the Wired Enroll bonus.

- ❑ Date of hire
- ❑ Plan selection
- ❑ Deductible and copay
- ❑ If selecting HSA integrated account with HealthEquity, must be noted
- ❑ Dates of birth for employees and dependents
- ❑ Employee SSN# (SSN# for all enrollees required if electing an HSA plan)
- ❑ Employee name
- ❑ Home address is physical address

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- ❑ Dates of birth for employees and dependents
- ❑ Employee SSN# (SSN# for all enrollees required if electing an HSA plan)
- ❑ Employee name
- ❑ Home address is physical address
- ❑ Dependent/spouse name(s)
- ❑ Signature (not needed for spreadsheet enrollment)
- ❑ Date

Waiver information required for eligible employees not enrolling:

- ❑ Type of coverage (group or individual)
- ❑ Current insurance company and plan policy number
- ❑ Eligible employee signature
- ❑ Date

Connect/Choice Plan Enrollment Form + Medical Home Selection Form - *forms only needed if enrolling in Connect or Choice plan*

- ❑ Use Connect/Choice Plan Enrollment form + Medical Home form, completing information as indicated above
- ❑ Complete in or out of area dependent enrollment in appropriate sections
- ❑ Subscriber name and medical home selection
- ❑ Dependent name(s) and medical home selection(s)

General / Miscellaneous

- ❑ Enrolling eligibles and their birthdates must match the quote (if not, Producer will need to requote)
- ❑ Copy of quote included
- ❑ Enrolling employees meet probationary period, or indicate “waive probationary period at initial enrollment”
- ❑ 75% employee participation requirement met
- ❑ Any / All employees working out-of-area must be identified

Optional Services

- ❑ HealthEquity - Visit **https://healthequity.tfaforms.net/43** to complete and submit online New Business Form if electing integrated HSA, HRA and/or FSA.

Providence Health Plan Underwriting Department reserves the right to request additional documents.

Deadlines for New Small Group Enrollment

For new groups, a clean and complete set of materials must be received in our office by the 20th of the prior month, or by the 25th if submitted via Wired Enroll. If you are submitting enrollment materials within 5 days of the enrollment deadline, we strongly recommend that you send your submission electronically.

Where to send Small Group Enrollments

Portland Office Mailing Address:
Providence Health Plan, Attn: Sales Small Group, PO BOX 4327, Portland, OR 97208
or
Email to: **Sales.ServiceA@providence.org** **or** **PDXSalesandServiceB@providence.org** **or** **Sales.ServiceC@providence.org** (depending on your team assignment, reach out to your Account Executive if you do not know). If you are submitting a manual application/enrollment to the Portland office via UPS, FedEx or a Courier, please direct it to 4400 NE Halsey, Suite 690, Portland, OR 97213. Please note that this address does not accept US Postal mail and is for courier and hand deliveries only.

Eugene Office Mailing Address:
Providence Health Plan, 1500 Valley River Dr. STE 240, Eugene, OR 97401
or
Email to: **PHPEugeneSGSales@providence.org**

Providence Health Plan

Oregon Small Group Master Contract Application 2024 Contact Year

Date _____

Legal name _____ Industry Type _____

DBA _____ NAICS Code _____
(Enter if different than legal name)

Requested effective date _____

Previous Providence Health Plan group? ☐ Yes ☐ No If yes, previous PHP group # _____

Contract contact _____

Mailing address:

_____

City _____ State, ZIP _____

Phone# _____ Fax# _____

Email address _____

Physical address:

_____

City _____ State, ZIP _____

County _____

Billing contact _____

Billing address: _____

City _____ State, ZIP _____

Phone# _____

Email Address _____

Business Fed Tax ID # (required) _____

CMS group size* _____

***CMS group size definition**: The Centers for Medicare & Medicaid Services determine group size as the current total number of nationwide full-time employees, part-time employees, seasonal employees and partners. Do not count retirees, COBRA-qualified beneficiaries, individuals on other continuation options, or self-employed individuals who participate in the employer's group health plan.

Subject to ☐ COBRA **or** ☐ State continuation

Dependents or students eligible to age 26.

Minimum hours required per week (17.5 or more) _____

Number of Benefit Eligible Employees _____

☐ Employee-only contract*
*By checking this box dependents are ineligible to enroll during the 12 month contract

The employer must contribute a minimum of 50% to the employee only rate of the least expensive plan offered to employees as required by law.

New Hire Eligibility

☐ First of the month following: ☐30 days ☐60 days ☐Date of hire

☐ First of the month following date of hire. If hired on the first of the month, coverage is effective that day.

☐ Day immediately following: ☐30 days ☐60 days ☐90 days

☐ Date of hire

Waive probationary period at initial enrollment? ☐ Yes ☐ No

Previous carrier _____ Previous group # _____

Remarks: _____

Portland office: PO Box 4327
Portland, OR 97208-4327
Phone: 1-877-245-4077
Fax: 503-574-7543

Eugene office: 1500 Valley River Drive, Suite 240
Eugene, OR 97401
Phone: 1-877-245-4077
Fax: 800-889-8218

OREGON SMALL GROUP PLAN OPTIONS

Total Enhanced *Indicate YES or NO: applying for Shop Credit*		
☐ Total Enhanced 250 Platinum	☐ Yes	☐ No
☐ Total Enhanced 500 Platinum	☐ Yes	☐ No
☐ Total Enhanced 750 Platinum	☐ Yes	☐ No
☐ Total Enhanced 1000 Gold	☐ Yes	☐ No
☐ Total Enhanced 1500 Gold	☐ Yes	☐ No
☐ Total Enhanced 2500 Gold	☐ Yes	☐ No
☐ Total Enhanced 3500 Gold	☐ Yes	☐ No
☐ Total Enhanced 4500 Gold	☐ Yes	☐ No
☐ Total Enhanced 5500 Gold	☐ Yes	☐ No
☐ Total Enhanced 7000 Gold	☐ Yes	☐ No

Balance *Indicate YES or NO: applying for Shop Credit*		
☐ Balance 750 Gold	☐ Yes	☐ No
☐ Balance 1500 Gold	☐ Yes	☐ No
☐ Balance 2500 Gold	☐ Yes	☐ No
☐ Balance 4000 Silver	☐ Yes	☐ No
☐ Balance 6000 Silver	☐ Yes	☐ No
☐ Balance 8000 Bronze	☐ Yes	☐ No

Standard *Indicate YES or NO: applying for Shop Credit*		
☐ Providence Oregon Standard Gold	☐ Yes	☐ No
☐ Providence Oregon Standard Silver	☐ Yes	☐ No
☐ Providence Oregon Standard Bronze	☐ Yes	☐ No

Domestic Partner
☐ Domestic Partner Plus

Connect *Indicate YES or NO: applying for Shop Credit*		
☐ Connect 750 Gold	☐ Yes	☐ No
☐ Connect 1500 Gold	☐ Yes	☐ No
☐ Connect 2500 Gold	☐ Yes	☐ No
☐ Connect 4000 Silver	☐ Yes	☐ No
☐ Connect 6000 Silver	☐ Yes	☐ No
☐ Connect 6900 Silver	☐ Yes	☐ No
☐ Connect 9450 Bronze	☐ Yes	☐ No

HSA Qualified *Indicate YES or NO: applying for Shop Credit*		
☐ HSA Qualified 1600 Gold	☐ Yes	☐ No
☐ HSA Qualified 2500 Silver	☐ Yes	☐ No
☐ HSA E Qualified 3500 Silver	☐ Yes	☐ No
☐ HSA E Qualified 5500 Bronze	☐ Yes	☐ No
☐ HSA E Qualified 6000 Bronze	☐ Yes	☐ No
☐ HSA E Qualified 7100 Bronze	☐ Yes	☐ No

Choice *Indicate YES or NO: applying for Shop Credit*		
☐ Choice 750 Gold	☐ Yes	☐ No
☐ Choice 1500 Gold	☐ Yes	☐ No
☐ Choice 2500 Gold	☐ Yes	☐ No
☐ Choice 4000 Silver	☐ Yes	☐ No
☐ Choice 6000 Silver	☐ Yes	☐ No
☐ Choice 6900 Silver	☐ Yes	☐ No
☐ Choice 9450 Bronze	☐ Yes	☐ No

Dental* *Dental enrollment & eligibility must match medical enrollment*	
☐ Essential Premier Dental	☐ Advantage Premier 1500 Dental
☐ Essential Value Access	☐ Advantage Premier 2000 Dental
☐ Essential Access Dental	☐ Advantage Access 1500 Dental
	☐ Advantage Access 2000 Dental

CDHP Accounts – The following integrated accounts are serviced by HealthEquity	
☐ Health Savings Account (HSA) *Can be paired with any HSA Qualified plan: no charge*	☐ Flexible Spending Account (FSA) *Can be paired with any non-HSA plan*
☐ Health Reimbursement Account (HRA) *Can be paired with any non-HSA plan*	☐ Limited Purpose Flexible Spending Account (LPFSA) *Can be paired with a HSA for dental and vision care*

***Pediatric Dental Disclaimer:** Some of our medical plan options DO NOT include pediatric dental coverage. Under the healthcare reform law (the Affordable Care Act or ACA), if you purchase our medical coverage outside of the Exchange, we must have reasonable assurance that you have obtained separate pediatric dental coverage through an Exchange-certified pediatric dental plan. This requirement applies whether you obtain coverage for children or adults. Exchange-certified pediatric dental plans can be found through the Federally Facilitated Marketplace, www.healthcare.gov. If you purchase a PHP Standard medical plan, adding the Providence Dental Plan for children aged 18 and younger does not satisfy the ACA pediatric dental Essential Health Benefit (EHB) requirement.

PROVIDENCE USE ONLY

	Medical Premium Totals				Dental Premium Totals
Tier	**Plan 1**	**Plan 2**	**Plan 3**	**Tier**	
S				**S**	
SS				**SS**	
SC				**SC**	
SSC				**SSC**	

Account Executive		**Check $**		**Eligible**	
Service Specialist		**Check #**		**Subscribers**	
Group #		**Total Premium $**		**Members**	

Portland office: PO Box 4327
Portland, OR 97208-4327
Phone: 1-877-245-4077
Fax: 503-574-7543

Eugene office: 1500 Valley River Drive, Suite 240
Eugene, OR 97401
Phone: 1-877-245-4077
Fax: 800-889-8218

PRODUCER INFORMATION

Producer_____Commission schedule *applies to medical & dental* = PMPM

Firm_____ Phone_____ National Producer Number#_____

Full address _____

Original contract will be mailed to the group; a copy will be mailed to the Producer.

PRODUCER STATEMENT

I certify that all the information contained in this application is correct to the best of my knowledge. I also certify that:

1. This firm is a bona fide business meeting the definition of Oregon Small Employer and/or a small employer as defined by HIPAA and complies with Providence Health Plan underwriting requirements for small employers.
2. All participation requirements have been met.
3. Coverage(s), enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the employer.

Dated this_____day of_____, 20_____

Print name and title

Producer signature

EMPLOYER STATEMENT

1. We wish to apply to enroll our firm as a group with Providence Health Plan. We understand payment of premium will be deemed to be assent to all terms of the group contract, including modifications and renewals that are sent to us.
2. We understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted.
3. Minimum participation requirements for specific coverage(s) have been fully explained in detail, and we understand that they must be met and maintained in order for the group to remain eligible for coverage.
4. We understand the obligation to provide the Summary of Benefits and Coverage (SBC) to eligible employees at open enrollment and when newly eligible or newly hired, as required by the Patient Protection and Affordable Care Act and related regulations and rules, and accept responsibility for delivering the document.
5. We affirm that if we choose a medical plan without pediatric dental coverage, we will obtain pediatric dental coverage, as required by federal law, and that we will notify Providence Health Plan if we do not obtain coverage.
6. The broker/producer stated above is our Producer of record for Providence Health Plan and will remain such until this application is rescinded in writing.
7. To the best of our knowledge and belief, the foregoing statements are true and complete and, along with the group application, shall be the basis for the issuance of coverage under the group policy and shall become part thereof.
8. We understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company; and such intent to defraud may be subject to criminal and civil penalties and Providence Health Plan may cancel the group account and refuse to pay claims.
9. We understand that 30 days' notice is required to change this agreement.
10. We affirm that we are contributing a minimum of 50% of the employee only rate of the least expensive plan offered to employees, as required by law.

Dated this_____day of_____, 20_____

Print name and title

Authorized group signature

Portland office: PO Box 4327
Portland, OR 97208-4327
Phone: 1-877-245-4077
Fax: 503-574-7543

Eugene office: 1500 Valley River Drive, Suite 240
Eugene, OR 97401
Phone: 1-877-245-4077
Fax: 800-889-8218

Providence Health Plan

Oregon Group Size Determination Form

For group health benefit plans purchased outside of the SHOP marketplace, this form must be completed for new and renewing groups to determine whether a group qualifies as a small employer.

If an employer has more than 50 Full Time (FT) and Full Time Equivalents ("FTE") employees, Providence Health Plan (PHP) may provide the employer a quote as a large group. PHP must treat the employer as a small group if the employer has at least one but not more than 50 FT and FTE employees.

To determine your workforce size for the purpose of determining your market size, you will:

1. Determine your total number of FT employees consistent with the instructions below;
2. Determine your total number of FTE employees consistent with the instructions below; and
3. Add your FT total and your FTE total together.

Please answer the following questions on page 2 so that we can determine the appropriate coverage for your business.

FT Counting Instructions

For each month of the prior calendar year, total the number of employees working an average of 30 hours or more per week during the calendar month or 130 hours or more during the calendar month. Divide that number by 12.

FTE Counting Instructions

For each calendar month of the prior calendar year, follow these two steps:

1. Combine the number of hours of service of all non-full-time employees for the month but do not include more than 120 hours of service per employee; and
2. Divide the total by 120.

To obtain your calendar year FTE total for use in the final market size calculation, add together the numbers for every calendar month of the prior calendar year, and divide that total number by 12.

The following employees should not be included in the count:

+ Leased employees
+ Contracted employees
+ Sole proprietors and partners in a partnership
+ 2-percent S corporation shareholders
+ Spouse of sole proprietors, a partner in partnership, or a 2-percent S corporation shareholder
+ Retired or former employees on continuation of coverage

Controlled and Affiliated Groups

Controlled and Affiliated Groups means groups that are commonly controlled and/or affiliated as described in subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986. If a group is a controlled or affiliated group of employers, a carrier must treat the group as a single group, and the controlled group must complete one group profile form.

Controlled Groups include parent-subsidiary, brother-sister, and the combination of both of the preceding.

Seasonal Workers

An employer is not considered to have more than 50 full-time employees (including full-time equivalent employees) if both of the following apply:

1. The employer's workforce exceeds 50 full-time employees (including full-time equivalent employees) for 120 days or fewer during the calendar year; and
2. The employees in excess of 50 employed during such 120-day period are seasonal workers.

Owners

In answering the questions about employees, an owner is generally not considered an employee even if the owner performs services for the business for compensation. However, an owner may participate in a group plan as long as the group employs at least *one common law employee that is enrolled in the plan, and that offers the group health plan to all full time employees.*

An Owner includes:

- A sole proprietor and the sole proprietor's spouse
- A member of a single-member limited liability company and the member's spouse
- The owner of a wholly owned corporation and the owner's spouse

GROUP INFO	
Company:	Renewal date:
PHP group number (if applicable):	
Address:	
Company headquarters (state):	
Contact name and title:	
Email address and telephone number:	
Producer name and telephone number:	

QUESTIONS	**ANSWERS**
1) Are you part of a controlled group?	
2) If you are part of a controlled group, who is the employer for purposes of filing taxes?	
3) How many FTs were in your group the prior calendar year? (If you are part of controlled group, this is the total FTs of the controlled group).	
4) How many FTEs were in your group the prior calendar year? (If you are part of controlled group, this is the total FTEs of the controlled group).	
5) What is the sum total of your answers to questions 3 and 4 above? If the answer is 51 or more, you are eligible for coverage in the large group market instead of the small group market.	
6) For the purpose of determining eligibility, employers must have at least one **benefit eligible and enrolling common law employee at the time of enrollment** (i.e. not an owner or spouse of owner). How many **enrolling common law employees, excluding owners and spouses of owners,** will be in your group as of the effective date of coverage?	
7) How many benefit eligible employees will be in your group as of the effective date of coverage?	

To the best of my knowledge, the above information is true and complete and shall be used during the group assessment process.

Print Name: _____ **Date:** _____

Signature: _____

Providence Health Plan

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

2024 Connect/Choice Enrollment/ Change of Status/Waiver Form

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

__/__/__ START OF ELIGIBILITY WAITING PERIOD

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

_____ SUBSCRIBER ID NUMBER

☐ Change in existing status: _____ REASON FOR STATUS CHANGE*

__/__/__ DATE OF STATUS CHANGE EVENT

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

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

CHOSEN PLAN FOR ENROLLMENT:

☐ Choice ☐ Connect

_____ PLAN DEDUCTIBLE

You will need to choose a medical home. A Medical Home Selection Form can be found on page 5.

1. Employee Information

_____ FIRST NAME

_____ LAST NAME

_____ MI

__/__/__ DATE OF BIRTH

_____ SOCIAL SECURITY NUMBER

_____ EMAIL

_____ PHONE

GENDER (CHECK ONE) ☐ Male ☐ Female ☐ Non-binary/Other ("U") MARITAL STATUS: ☐ Married ☐ Single

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 Information:* (If waiving, see question 3)

Please include full, legal names.

1

LAST NAME | FIRST NAME, MI | RELATION | SOCIAL SECURITY # | __/__/__ DATE OF BIRTH

Gender: ☐ M ☐ F ☐ Non-binary/Other ("U") Lives with policyholder? ☐ Y ☐ N **If no, please include home address**

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.)

DEPENDENT'S HOME ADDRESS | APARTMENT/UNIT NUMBER

CITY | STATE | ZIP | COUNTY

2

LAST NAME | FIRST NAME, MI | RELATION | SOCIAL SECURITY # | __/__/__ DATE OF BIRTH

Gender: ☐ M ☐ F ☐ Non-binary/Other ("U") Lives with policyholder? ☐ Y ☐ N **If no, please include home address**

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.)

DEPENDENT'S HOME ADDRESS | APARTMENT/UNIT NUMBER

CITY | STATE | ZIP | COUNTY

3

LAST NAME | FIRST NAME, MI | RELATION | SOCIAL SECURITY # | __/__/__ DATE OF BIRTH

Gender: ☐ M ☐ F ☐ Non-binary/Other ("U") Lives with policyholder? ☐ Y ☐ N **If no, please include home address**

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.)

DEPENDENT'S HOME ADDRESS | APARTMENT/UNIT NUMBER

CITY | STATE | ZIP | COUNTY

4

LAST NAME | FIRST NAME, MI | RELATION | SOCIAL SECURITY # | __/__/__ DATE OF BIRTH

Gender: ☐ M ☐ F ☐ Non-binary/Other ("U") Lives with policyholder? ☐ Y ☐ N **If no, please include home address**

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.)

DEPENDENT'S HOME ADDRESS | APARTMENT/UNIT NUMBER

CITY | STATE | ZIP | COUNTY

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

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

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.

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

Providence Medical Home Selection Form

About this form

Some health plans utilize a team of health care professionals led by a primary care provider at a designated clinic, referred to as a medical home, to provide and arrange care.

To maximize the benefits and value of your medical home plan, please designate a medical home provider for yourself and each enrolled dependent. You may choose the same or different medical homes for you and your enrolled dependents. **In the event a medical home is not chosen, one will be chosen for you.**

Medical home selections may be made through **myProvidence.org***, by calling customer service at **503-574-7500** or **800-878-4445 (TTY: 711)**, or by completing the sections below and returning this form via fax to **503-574-8208**, or by U.S. mail to:

Providence Health Plan
P.O. Box 4327
Portland, OR 97208

1. Subscriber Information

FIRST NAME _____ MI _____ LAST NAME _____

MEMBER ID NUMBER _____ GROUP NUMBER _____ PHONE _____ MEDICAL HOME _____

2. Dependent Information and Medical Home Selection

Please indicate member information and a medical home selection below. Refer to the provider directory available at **ProvidenceHealthPlan.com/ProviderDirectory** for medical home options. If you need more space, please use a separate page.

FIRST NAME	LAST NAME	MI	MEMBER ID #	MEDICAL HOME

Contact Information

For more information about your plan benefits and/or information about a specific medical home, please contact customer service at **503-574-7500** or **800-878-4445**, or **ProvidenceHealthPlan.com/ContactUs**

*After enrollment and upon creation of a free myProvidence account.

Providence Health Plan

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

2024 Enrollment/Change of Status/ Waiver Form

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 _____ START OF ELIGIBILITY WAITING PERIOD __/__/__

☐ New enrollment ☐ Open enrollment ☐ Waiver of coverage (see section 4) SUBSCRIBER ID NUMBER _____

☐ Change in existing status: REASON FOR STATUS CHANGE* _____ DATE OF STATUS CHANGE EVENT __/__/__

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

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

CHOSEN PLAN FOR ENROLLMENT:

☐ Total Enhanced ☐ Balance ☐ Standard ☐ HSA ☐ Integrated Health Savings Account with HealthEquity®

I have read and agreed to the HSA authorization form.

PLAN DEDUCTIBLE _____

1. Employee Information

FIRST NAME _____ LAST NAME _____ MI _____ DATE OF BIRTH __/__/__

SOCIAL SECURITY NUMBER _____ EMAIL _____ PHONE _____

GENDER (CHECK ONE) ☐ Male ☐ Female ☐ Non-binary/Other ("U") MARITAL STATUS: ☐ Married ☐ Single

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 Information:* (If waiving, see question 3)

Please include full, legal names.

1

LAST NAME | FIRST NAME, MI | RELATION | SOCIAL SECURITY # | __/__/__ DATE OF BIRTH

Gender: ☐ M ☐ F ☐ Non-binary/Other ("U") Lives with policyholder? ☐ Y ☐ N **If no, please include home address**

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.)

DEPENDENT'S HOME ADDRESS | APARTMENT/UNIT NUMBER

CITY | STATE | ZIP | COUNTY

2

LAST NAME | FIRST NAME, MI | RELATION | SOCIAL SECURITY # | __/__/__ DATE OF BIRTH

Gender: ☐ M ☐ F ☐ Non-binary/Other ("U") Lives with policyholder? ☐ Y ☐ N **If no, please include home address**

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.)

DEPENDENT'S HOME ADDRESS | APARTMENT/UNIT NUMBER

CITY | STATE | ZIP | COUNTY

3

LAST NAME | FIRST NAME, MI | RELATION | SOCIAL SECURITY # | __/__/__ DATE OF BIRTH

Gender: ☐ M ☐ F ☐ Non-binary/Other ("U") Lives with policyholder? ☐ Y ☐ N **If no, please include home address**

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.)

DEPENDENT'S HOME ADDRESS | APARTMENT/UNIT NUMBER

CITY | STATE | ZIP | COUNTY

4

LAST NAME | FIRST NAME, MI | RELATION | SOCIAL SECURITY # | __/__/__ DATE OF BIRTH

Gender: ☐ M ☐ F ☐ Non-binary/Other ("U") Lives with policyholder? ☐ Y ☐ N **If no, please include home address**

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.)

DEPENDENT'S HOME ADDRESS | APARTMENT/UNIT NUMBER

CITY | STATE | ZIP | COUNTY

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

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

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.

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 are optional. Your responses will help us to better serve all communities.

MEMBER NAME _____ GROUP NAME/NUMBER _____

Which of the following describes your racial or ethnic identity? Please check all that apply.

Hispanic and 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
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Other

- ☐ Other
- ☐ I don't know.
- ☐ I don't want to answer.

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

White

- ☐ Caucasian/White (no national affiliation)
- ☐ Eastern European/Slavic
- ☐ Western European
- ☐ Other White (African, Australian, New Zealand descent)

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Black or African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Afro-Latinx/Bi-racial/Other
- ☐ Other Black

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

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.

Providence Health Plan

2024 Small Group Guidelines

Plan Requirements

1) Choice/Connect may be offered on a stand-alone basis. Out-of-area (OOA) dependents (spouse or domestic partner, child, step-child or legally adopted child) not living with the employee may enroll as an OOA dependent by completing the OOA dependent enrollment section of the Choice/ Connect form. Out of area dependents cannot remain on the standard Connect plan.
2) Dependents must enroll in the same benefit option as the employee.

Multiple Plan Option Requirements

1) Available for all small employers.
2) The employer must contribute a minimum of 50% of the employee only rate of the lowest premium plan chosen. If a dollar amount contribution is chosen, the amount must at least equal 50% of the employee only rate of the lowest premium plan chosen.
3) A small employer with 1-4 enrolled employees may choose up to two small group plans. A small employer with 5 or more enrolled employees may choose up to three small group plans.
4) At time of sale plans without enrollment will not be offered. The exceptions are when enrollment is only in an HSA plan, when a Connect or Choice plan is purchased and a Signature plan is required, or when the plan without enrollment is the lowest cost plan.
5) There are no restrictions on plan pairings.

Additional Underwriting Requirements

1) An eligible Oregon Small Group employer is an employer having an average of at least one but not more than a combined total of 50 full-time (FT) and full time equivalent (FTE) employees during the preceding calendar year and who employs at least one benefit eligible employee on the first day of the plan year.
2) The employer must have at least one common law employee that is enrolled in the plan, and offers the group health plan to all benefit eligible employees.
3) The employer must be located in the Providence Health Plan Oregon service area.
4) The employer must have at least 50% of enrolling employees working or residing in Oregon and Washington state
5) Choice products are available to employers located in Oregon Counties of Baker, Benton, Clackamas, Clatsop, Coos, Crook, Curry, Deschutes, Douglas, Hood River, Jackson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Umatilla, Union, Wallowa, Washington and Yamhill.
6) Connect products are only available to employers located in Clackamas, Multnomah, Hood River, Yamhill (zip codes 97132 and 97123 only) and Washington counties. Employees who enroll on these plans must work or reside in these same counties.

7) Products are offered on a sole carrier basis.
8) The employer may determine hours worked for benefit eligibility between 17.5 and 40 hours per week.
9) 75% of benefit eligible employees must enroll or show proof of other valid coverage. There is no minimum participation requirement for dependents.
10) Valid waivers include those waiving for other group or individual coverage. Waivers for other types of coverage are subject to underwriting review.
11) The employer must contribute a minimum of 50% to the employee only rate of the least expensive plan offered to employees.
12) Employee only contracts are available.
13) The employer must elect a probationary period from the following: (1) Date of hire (2) Day immediately following 30, 60 or 90 days (3) First of the month following DOH, 30 or 60 days.
14) Dependents are eligible for coverage up to age 26.
15) If an employer offers different benefits to different classes of employees, all other contract provisions such as contribution, probationary period and hourly requirements must be the same for all employees, regardless of class.
16) Premium is due on or before the first of the month for which coverage is provided. Payment at time of enrollment does not constitute coverage without UW approval.

Open Enrollment Period

1) If an employer does not meet the minimum contribution or participation requirements, they may only enroll during the period of November 15th through December 15th, for a January 1st effective date.
2) If an employer does not meet our contribution or participation requirements at renewal, we may decline to renew.

Dental Guidelines

1) Dental enrollment and eligibility must match medical enrollment.
2) Providence dental plans are only offered on a sole carrier basis and cannot be offered to a group with another dental carrier in place.
3) Employer can only choose one Providence dental plan.
4) Dental can only be purchased in conjunction with a medical plan through Providence.