Providence Health Enrollment

Questions? Call us at 1.800.884.2343

Prefer an electronic application?

- We're sorry but Providence doesn't currently have an electronic application.

Tips for completing the application:

- Please read everything carefully and answer all questions honestly. This document becomes part of your health insurance contract.
- Please complete all sections to the best of your ability.
- The section about your health information is to make sure that you get all the support care you may need. It is not required to complete this section.

Payment Options:

- Once you are approved, you will be contacted by Providence to set up your payment method.

Final check list before mailing:

- ✓ All sections completed?
- ✓ Signed and Dated
- ✓ Voided check if selecting the automated monthly withdrawal

Send Completed Application to:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Toll-free FAX: 1.888.632.5470 or 541.284.2994
Email: cs@cda-insurance.com
Secure File Upload: Click here

Changing Plans?

You may change plans only during the Open Enrollment period or if you are eligible for a Special Enrollment. This application must be received by the end of the Open Enrollment period or the end of the Special Enrollment period.

If you're changing plans, your new plan will take effect on the first of the month following receipt of this application.

2017 Oregon Application for Individual & Family Insurance

ProvidenceHealthPlan.com 503-574-5000 800-988-0088

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 Email: PHPindapp@providence.org

Complete all sections of this application. See pages 5-6 for information to help you with the application.
If you need assistance, please contact your insurance producer or agent or call the Providence Health Plan Sales Team at 503-574-5000 or 1-800-988-0088, TTY: 711.

Step1: Type of Application (please choose one):

New Enrollment (Nov. 1, 2016 – Jan. 31, 2017)	**Special Enrollment** (Feb. 1, 2017 – Dec. 31, 2017)
Effective date: ___________ See page 5 for details. ☐ 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 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. *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.	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: ___________ See page 5 for details. ☐ Marriage or Domestic Partner ☐ 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 ☐ Involuntary termination of COBRA coverage ☐ Qualified Medical Child Support Order (QMCSO) ☐ Lose or become eligible for state premium assistance under a Medicaid or CHIP program ☐ No longer residing in the service area ☐ The person is a survivor of domestic abuse/violence or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner.

Step 2: Enroll for coverage

2A Information for Policyholder (age 18 and older)

Applicant/ Policyholder Last Name		**First Name**			**Middle Initial**
Home Address (**No Post Office Box**)		City	State	Zip Code	County
Mailing Address (if different from Home Address)		City	State	Zip Code	County
Home/cell Phone Number (**Required**)	Work Phone/Other Phone Number	Email Address			
Date of Birth (MM-DD-YYYY)	**Social Security Number**	**Gender** 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 Information for Spouse or Domestic Partner to be included in this policy

(Please fill out completely)

Spouse/Domestic Partner Last Name			First Name	Middle Initial
Date of Birth (MM-DD-YYYY)	Social Security Number	Gender 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 List additional Family Member(s) to be included in this policy

(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)

Last Name	First Name, Middle Initial	Gender	Date of Birth (MM-DD-YYYY)	Social Security Number
1. Dependent Child		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☐				
2. Dependent Child		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☐				
3. Dependent Child		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☐				
Please explain your relationship to any person listed above whose last name is different from the 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 Billing Information if different from above

(Complete this section only if billing information should be sent to an address or person other than listed above.)

Name		Relationship to Applicant or Dependent			
Mailing Address 1	Mailing Address 2	City	State	Zip Code	

2E Address Information for dependent(s) in 2C on a dependent-only policy if different from 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

Step 3: Choose a Medical Plan

Check one	Plan Name	Network	Deductible (in-network)	Out of Pocket Maximum (in-network)
☐	Balance 2500 Silver	Providence Signature Network	$2,500/$5,000	$7,150/$14,300
☐	Balance 7150 Bronze	Providence Signature Network	$7,150/$14,300	$7,150/$14,300
☐	Choice 2500 Silver	Providence Choice Network	$2,500/$5,000	$7,150/$14,300
☐	Choice 7150 Bronze	Providence Choice Network	$7,150/$14,300	$7,150/$14,300
☐	Connect 2500 Silver	Providence Connect Network	$2,500/$5,000	$7,150/$14,300
☐	Connect 7150 Bronze	Providence Connect Network	$7,150/$14,300	$7,150/$14,300
☐	HSA 2800 Silver	Providence Signature Network	$2,800/$5,600	$5,000/$10,000
☐	HSA 6000 Bronze	Providence Signature Network	$6,000/$12,000	$6,550/$13,100
☐	OR Standard Gold Plan	Providence Signature Network	$1,000/$2,000	$6,850/$13,700
☐	OR Standard Silver Plan	Providence Signature Network	$2,500/$5,000	$6,850/$13,700
☐	OR Standard Bronze Plan	Providence Signature Network	$7,150/$14,300	$7,150/$14,300
☐	OR Standard Gold Plan Area D*	Providence Signature Network	$1,000/$2,000	$6,850/$13,700
☐	OR Standard Silver Plan Area D*	Providence Signature Network	$2,500/$5,000	$6,850/$13,700
☐	OR Standard Bronze Plan Area D*	Providence Signature Network	$7,150/$14,300	$7,150/$14,300
☐	OR Standard Gold Plan Area G*	Providence Signature Network	$1,000/$2,000	$6,850/$13,700
☐	OR Standard Silver Plan Area G*	Providence Signature Network	$2,500/$5,000	$6,850/$13,700
☐	OR Standard Bronze Plan Area G*	Providence Signature Network	$7,150/$14,300	$7,150/$14,300

***If you live in Coos or Curry counties and want a Standard plan, choose the Area D options. If you live in Baker, Crook, Grant, Harney, Jefferson, Malheur, Umatilla, Union, or Wallowa, counties and want a Standard plan, choose the Area G options**

****If you selected a Choice or Connect plan, you will need to choose a medical home and a primary physician/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 or call our Sales team at 1-800-988-0088.

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, HealthCare.gov.

Step 4: Add dental coverage (optional)

Check to choose dental	Dental Plan	People to be covered
☐	Providence Progressive Dental	

Please note: 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 under age 19 who are enrolled on the Balance, HSA, Choice and Connect plans, this coverage will be supplemental to the pediatric dental coverage already included under the medical plan.

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

Step 5: 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 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 "Privacy Notices & Policies" or by calling Customer Service.

Signature

1. I understand that Providence Health Plan will:
   a. notify me in writing as to the status of my application.
   b. send me a legal contract upon enrollment.
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.
4. I affirm that if I choose a medical plan without pediatric dental coverage, I will obtain pediatric dental coverage through a separate Cover Oregon-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 Applicant (or the Parent/Legal Guardian signature for a Dependent-Only application) X ______________________	Relationship to dependent applicant under 18:	Date
Please PRINT name of Applicant		
Signature of Spouse or Domestic Partner* X ______________________ ☐ Signed by applicant for 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
Agent E-mail	Phone Number	Fax Number
Agent Signature X ______________________	Date:	

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

Application instructions:

Please PRINT clearly in black or blue ink and mail, fax or email your completed application and any necessary documentation to:

Providence Health Plan, P.O. Box 4649, Portland, OR 97208-4649 Email: PHPindapp@providence.org

Do **not** include payment with this application.

Complete all sections of this application. Make sure to include your requested effective date (page 1) and home address and phone number (page 1). If the application is incomplete or additional information is required, your effective date may be delayed.

You will be notified by mail regarding the status of your application. If for any reason there is a delay in the application process, Providence Health Plan will move your requested effective date forward to the next available date.

All policyholders and dependents listed on this application must reside in the state of Oregon except a dependent-only policyholder who is enrolling dependent(s) who reside in Oregon on a dependent-only policy.

If you need assistance, please contact your insurance producer or agent or call the Providence Health Plan Sales Team at 503-574-5000 or 1-800-988-0088, TTY: 711.

Information to help you fill out this application:

Effective dates:
The Effective Date of Coverage is determined by the date Providence Health Plan receives your completed application as well as the date Providence Health Plan receives the initial Premium. See table below:

Date application is received	Coverage effective date	Date initial payment must be received by Providence
Open Enrollment		
Nov. 1 – Dec. 15, 2016	Jan. 1, 2017	Jan. 1, 2017
Dec. 16, 2016 – Jan. 15, 2017	Feb. 1, 2017	Feb. 1, 2017
Jan. 16 – Jan. 31, 2017	Mar. 1, 2017	Mar. 1, 2017
Special Enrollment		
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

Please note: All plans purchased using this application will expire Dec. 31, 2017.

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:

- Except when the Qualifying Event is the birth, adoption, or placement for adoption or foster care; coverage will be effective the first day of the month following our receipt of the application, provided the initial Premium is received by the first day of the effective 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 60 days of birth, adoption, or placement.

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Payment information:
An offer letter confirming the receipt of your application will be mailed to you. Your initial premium payment must be received by the effective date (please refer to Effective Date table located in this document.) Personal checks, VISA/MasterCard debit or credit cards are accepted.

Your initial premium payment must be received by the effective date.
Please do not send a payment with this paper application. You will receive a letter 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).
After the initial payment, you will receive a monthly invoice from Providence Health Plan. Methods of payment include personal check, debit/credit card (Visa or MasterCard only), auto-pay (sign up at www.Providence.org/billpay), or you may make payments using online bill pay from your financial institution.

Glossary of terms:

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

Important Information about Medicare:

Are you age 65 or over and entitled to Medicare? Yes ☐ No ☐

Are you a Medicare Recipient due to disability or End Stage Renal Disease? Yes ☐ No ☐

If you answered "yes," you may not be eligible to enroll in this plan. The federal government does not allow health plans to issue Individual coverage that duplicates coverage available through Medicare.

Questions? Call your insurance producer or agent or the PHP Medicare sales team at 503-574-5551 or 1-800-457-6064.

Important information about Dental coverage:

Our optional Providence Progressive Dental plan provides benefits for adults and children for an additional monthly premium per person, per month. If you choose Providence Progressive Dental, all people on the policy will be enrolled and charged the dental premium amount in addition to the medical plan premium. In order to purchase the Providence Progressive Dental Plan, you must also purchase a PHP medical plan.

If you purchase a PHP Standard or Essential medical plan, adding the Providence Progressive Dental Plan for children aged 18 and younger does not satisfy the ACA pediatric dental Essential Health Benefit (EHB) requirement.

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

Important information about Choice and Connect plans:

If you select a Choice or Connect plan, you must choose a medical home. For more information about these plans, please visit ProvidenceHealthPlan.com. To see a list of medical homes, visit ProvidenceHealthPlan.com/findaprovider.

Before you submit this application, did you remember to:

- Include home address and phone number (page 1)
- Select an effective date (page 1)
- Select a medical plan (page 3)
- Sign and date (page 4)

Sections you need to complete by application type:

- Myself only: 1, 2A, 2D, 3, 4, 5
- Myself/spouse or domestic partner: 1, 2A, 2B, 2D, 3, 4, 5
- Myself and children: 1, 2A, 2C, 2D, 2E, 3, 4, 5
- Myself and family: 1, 2A, 2B, 2C, 2D, 2E, 3, 4, 5
- Dependent(s) only: 1, 2A, 2C, 2D, 2E, 3, 4, 5