_____
Date form distributed

_____
Effective date

_____
Date election period expires

Oregon Continuation Election Form

For Employer Groups with 19 or fewer employees, or Employer Groups not subject to COBRA

PROVIDENCE Health Plan

If you wish to apply for Oregon continuation coverage, you must complete all sections of this form and return it to your employer within 10 days of the qualifying event or 10 days of receiving your notice of continuation coverage, whichever is later.

SECTION 1 QUALIFYING INDIVIDUAL INFORMATION

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DAYTIME PHONE

ADDRESS (STREET, CITY, STATE, ZIP CODE)	MEMBER ID NO.	GROUP NO.

DATE OF BIRTH	GENDER	MARITAL STATUS
	☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

SECTION 2 QUALIFYING EVENT INFORMATION

I am eligible for continuation of medical coverage due to:

☐ Termination of employment. Employment termination date: _____

☐ Reduction in work hours. Reduction effective date: _____

☐ Covered employee becoming eligible for Medicare. Medicare eligibility effective date: _____

☐ Divorce or legal separation from a covered employee. Divorce or legal separation date: _____

☐ Death of a covered employee. Date of death: _____

☐ Termination of membership in group health plan. Membership termination date: _____

☐ Covered dependent child no longer meets eligibility requirements. Loss of eligibility effective date: _____

Is anyone applying for continuation covered by another group insurance? ☐ Yes ☐ No

If yes, name of insured: _____ Insurance carrier: _____

If you are not the covered employee, give the name and member ID number of the employee who is primary on the policy:

Name: _____ Member ID No.: _____

SECTION 3

Please list all dependent family members continuing coverage.

Last Name	First Name	Middle Initial	Date of Birth	Gender	Relationship

SECTION 4 SIGNATURE OF QUALIFYING INDIVIDUAL

Accuracy of information: Any person who, with an intent to knowingly defraud, files this election form with the 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 claims.

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 this state continuation election form) for the purpose of: (a) performing the health plan business operation s 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 www.ProvidenceHealth Plan.com or by calling customer service.

SIGNATURE: _____ DATE: _____