Providence Health Plan

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

2026 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: employment change (e.g., promotion), 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

Note: Care must be accessed through a medical home. A medical home must be designated for each covered dependent. Please refer to the Medical Home Selection Form 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 enroll, please include 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 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.