Oregon Small Group
ENROLLMENT CHECKLIST FOR PRODUCERS
2020 Contract Year

Materials for new groups must be received in our office by the 20th of the month.

Remember Wired Enroll! Enroll and submit your group electronically through Wired Enroll/Wired Quote. From Wired Quote, while viewing the proposal, simply click "To enroll this group, click here!" and you will be directed to Wired Enroll. From there you can simply complete the Master Contract Application, Group Size Determination Form, Spreadsheet Enrollment (using the exact quote you processed in Wired Quote, so your quote always matches your enrollment), and sign/submit the documents securely to Providence Health Plan.

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 Spreadsheet

Quoted census from WiredQuote can be transferred directly into spreadsheet enrollment -- see instructions in WiredQuote

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

- ❑ Use Connect 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 new group notification form completed if electing integrated HSA, HRA and/or FSA - remit to **onboarding@healthequity.com**

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

Deadlines for New Small Group Enrollment

In order to provide excellent service to our members, Providence Health Plan has a deadline for new small group enrollment.

For **NEW GROUPS**, materials must be received in our office by the **20th of the month** for first of the month effective dates. For **Wired Enroll groups**, materials must be received in our office by the **25th of the month** for first of the month effective dates. (Groups effective January 1, 2020 must be received by December 16, 2019.)

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.

Portland Office Mailing Address: Providence Health Plan
attn: Sales Small Group
PO BOX 4327
Portland, OR
97208

For Producers serviced by the Portland office: *New Small Group enrollment materials submitted within 5 days of the enrollment deadline should be sent via courier, UPS, or FedEx directly to our Portland office address:*
4400 NE Halsey Suite 690, Portland, OR 97213.
This address does not receive US postal mail and is for courier and hand deliveries only.

Eugene Office Mailing Address: Providence Health Plan
1500 Valley River Dr. STE 200
Eugene, OR
97401

Please remember that achieving deadlines does not guarantee group coverage. Providence Health Plans Underwriting Department must review group's enrollment materials to ensure all underwriting criteria are met.

The document needed to enroll a group using Spreadsheet Enrollment (in lieu of enrollment forms) can be downloaded at https://healthplans.providence.org/~/media/Files/Providence%20HP/pdfs/producers/Documents/Enrollment%20Spreadsheet.zip

As noted on pg.1, a quoted census can also be transferred directly from WiredQuote into the PHP spreadsheet template. Simply follow the instructions in Wired Quote to transfer your quoted census to the enrollment spreadsheet, complete the remaining columns in the spreadsheet and submit securely to Providence with the other needed enrollment materials.

PROVIDENCE Health Plan

Oregon Small Group
MASTER CONTRACT APPLICATION
2020 Contract 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 _____

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 200
Eugene, OR 97401
Phone: 1-877-245-4077
Fax: 800-889-8218

OREGON SMALL GROUP PLAN OPTIONS

Total Enhanced
☐ Total Enhanced 250 Platinum
☐ Total Enhanced 500 Platinum
☐ Total Enhanced 1000 Gold
☐ Total Enhanced 1500 Gold
☐ Total Enhanced 2500 Gold
☐ Total Enhanced 3500 Gold
☐ Total Enhanced 4500 Gold
☐ Total Enhanced 5500 Gold
☐ Total Enhanced 7000 Silver

Balance
☐ Balance 750 Gold
☐ Balance 1500 Gold
☐ Balance 2500 Silver
☐ Balance 3500 Silver
☐ Balance 4500 Silver
☐ Balance 6000 Silver
☐ Balance 7000 Bronze
☐ Balance 8150 Bronze

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

Connect
☐ Connect 750 Gold
☐ Connect 1500 Gold
☐ Connect 2500 Silver
☐ Connect 3500 Silver
☐ Connect 4500 Silver
☐ Connect 6000 Silver
☐ Connect 7000 Bronze
☐ Connect 8150 Bronze

HSA Qualified
☐ HSA Qualified 2000 Silver
☐ HSA Qualified 2500 Silver
☐ HSA Qualified 3500 Silver
☐ HSA Qualified 4500 Bronze
☐ HSA Qualified 5500 Bronze
☐ HSA Qualified 6750 Bronze

Dental *Dental enrollment & eligibility must match medical enrollment*
☐ Providence Essential Dental
☐ Providence Essential Access Dental
☐ Providence Advantage Access Dental
☐ Providence Preventive Dental

Domestic Partner
☐ Domestic Partner Plus

CDHP Accounts – The following integrated accounts are serviced by HealthEquity	
☐ Health Savings Account (HSA) *Can be paired with any HSA Qualified plan*	☐ 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 200
Eugene, OR 97401
Phone: 1-877-245-4077
Fax: 800-889-8218

PRODUCER INFORMATION

Producer_____Commission schedule *applies to medical & dental* = PMPM

Firm_____ Phone_____ Producer#_____

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 200
Eugene, OR 97401
Phone: 1-877-245-4077
Fax: 800-889-8218

PROVIDENCE Health Plans

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, 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:

- Temporary employees
- Seasonal employees
- 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.

PROVIDENCE Health Plans

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 employees will be in your group as of the effective date of coverage? (This number is your total employee headcount.)	
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.

Completed by:

Print Name _____ Date: _____

Signature _____

2020 Connect Enrollment/Change of Status/Waiver Form

PROVIDENCE Health Plan

P.O. Box 4327, Portland, OR 97208-4327, 800-878-4445, **ProvidenceHealthPlan.com**.
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 _____ ☐ New enrollment ☐ Open enrollment ☐ Waiver of coverage (see section 4) START OF ELIGIBILITY WAITING PERIOD __/__/__

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

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

*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.

PLAN DEDUCTIBLE _____

As a Connect member, you will need to choose a Medical Home. A Medical Home Selection Form can be found on page 3.

1. Employee Information

FIRST NAME _____ LAST NAME _____ MI _____ DATE OF BIRTH __/__/__ SOCIAL SECURITY NUMBER _____

MARITAL STATUS: ☐ Married ☐ Single GENDER: ☐ Male ☐ Female PHONE _____ EMAIL _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

2a. In-Area Dependent Enrollment Information (If waiving, see question 4.)

ADD	DROP	FIRST NAME	LAST NAME	MI	RELATION	SOCIAL SECURITY #	DATE OF BIRTH	GENDER
☐	☐							
☐	☐							
☐	☐							

2b. Out-of-Area Dependent Enrollment Information (If waiving, see question 4.)

ADD	DROP	FIRST NAME	LAST NAME	MI	RELATION	SOCIAL SECURITY #	DATE OF BIRTH	GENDER
☐	☐							
		ADDRESS:		CITY:		STATE:	ZIP:	
☐	☐							
		ADDRESS:		CITY:		STATE:	ZIP:	

Is the insurance of any dependents affected by divorce decree/court order? ☐ Yes ☐ No If YES, include portion of decree showing responsibility for medical expenses.

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

Have you had prior Providence Health Plan health coverage? ☐ Yes ☐ No If YES, please list previous member ID number:

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

PROVIDENCE Health Plan

NOTE: If you are a PEBB Providence Choice member, please use the PEBB-specific Medical Home Selection Form.

About this Form

Some of our 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 faxing to 503-574-8208, returning this form via email to **MedicalHomeSelectionForms@providence.org**, 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** or the medical home list for medical home options. If you need more space, please use a separate page.

FIRST NAME	LAST NAME	MI	MEMBER ID #	MEDICAL HOME (REFER TO PROVIDER DIRECTORY)

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.

2020 Enrollment/Change of Status/Waiver Form

PROVIDENCE Health Plan

P.O. Box 4327, Portland, OR 97208-4327, 800-878-4445, **ProvidenceHealthPlan.com**.
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 _____ ☐ New enrollment ☐ Open enrollment ☐ Waiver of coverage (see section 4) START OF ELIGIBILITY WAITING PERIOD __/__/__

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

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

*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.

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 _____

MARITAL STATUS: ☐ Married ☐ Single GENDER: ☐ Male ☐ Female PHONE _____ EMAIL _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

2. Dependent Enrollment Information (If waiving, see question 4.)

ADD	DROP	FIRST NAME	LAST NAME	MI	RELATION	SOCIAL SECURITY #	DATE OF BIRTH	GENDER
☐	☐							
☐	☐							
☐	☐							
☐	☐							
☐	☐							
☐	☐							

Is the insurance of any dependents affected by divorce decree/court order? ☐ Yes ☐ No If YES, include portion of decree showing responsibility for medical expenses.

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

Have you had prior Providence Health Plan health coverage? ☐ Yes ☐ No If YES, please list previous member ID number:

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

Plan Requirements

1) 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 Connect form.

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 exception is 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 51% of enrolling employees working or residing in the Signature service area (PHP OR service area plus Clark, Klickitat and Skamania counties in WA).
5) Connect products are only available to employers located in Clackamas, Multnomah, Hood River, Yamhill (zip code 97132 only) and Washington counties. Employees who enroll on these plans must work or reside in these same counties.
6) Products are offered on a sole carrier basis.
7) The employer may determine hours worked for benefit eligibility between 17.5 and 40 hours per week.
8) 75% of benefit eligible employees must enroll or show proof of other valid coverage. There is no minimum participation requirement for dependents.
9) Valid waivers include those waiving for other group or individual coverage. Waivers for other types of coverage are subject to underwriting review.
10) The employer must contribute a minimum of 50% to the employee only rate of the least expensive plan offered to employees.
11) Employee only contracts are available.
12) 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.
13) Dependents are eligible for coverage up to age 26.

14) 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.
15) 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.

HSA/HRA Standard new business notification form

HealthEquity

Please complete this form online at: https://sales.healthequity.comonboarding/

or

Complete the form below and email to HealthEquity at onboarding@healthequity.com

New Business Information

Once your new business form is received, you will receive a phone call or email from one of our representatives within two business days to discuss the steps to implement your new plans.

Company name		Tax ID	
Primary contact	Email	Phone (area code)	
Street address	City	State	ZIP

ER entity

☐ C corp ☐ S corp ☐ Sole proprietorship ☐ LLC ☐ Gov. or church ☐ Non-profit ☐ Other_____

An HRA may provide tax-free benefits only to employees, former employees, retirees, and their spouses or covered tax dependents. Because self-employed individuals are not "employees," an HRA may not provide tax-free benefits to self-employed individuals (i.e., sole proprietors, partners, and more-than-2% Subchapter S corporation shareholders).

Who is your health plan provider? _____

Onboarding call information

Who should be included in the intial onboarding call?

Contact name	Contact type	Phone	Email
Contact name	Contact type	Phone ( )	Email
Contact name	Contact type	Phone ( )	Email
Contact name	Contact type	Phone ( )	Email

Was a HealthEquity representative part of the sales process?

☐ No ☐ Yes If yes, who was the HealthEquity representative? _____

Number of benefit-eligible employees: _____ **Effective date of plan:** _____

When do employees become eligible for benefits (ie. date of hire, after 30 days)? _____

Product sold

HSA	**Estimated number of accounts:** _____ **Are there HSAs to transfer from another administrator?** ☐ No ☐ Yes If yes, who is the current administrator? _____
FSA	**Estimated number of accounts:** _____ ☐ Full FSA ☐ Limited-purpose FSA ☐ Dependent care reimbursement account Do you want a debit card for your FSA and/or LPFSA? ☐ Yes ☐ No
HRA	**Estimated number of accounts:** _____ ☐ Member pays first ☐ HRA pays first ☐ HRA with a debit card ☐ HRA with incentive