Date form distributed ______________

Effective date ______________

Date election period expires ______________

Oregon Continuation Election Form

19 OR FEWER EMPLOYEES

If you wish to apply for Oregon continuation coverage, you must complete all sections of this form and return it to your employer within 31 days from the date you receive your notice of continuation coverage.

SECTION 1 QUALIFYING INDIVIDUAL INFORMATION

LAST NAME	FIRST	M.I.	MEMBER ID NO.	GROUP NO.

ADDRESS (STREET, CITY, STATE, ZIP CODE)	DAYTIME PHONE

DATE OF BIRTH	SEX	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 or reduction in hours – Employment termination date: ______________
- ☐ Divorce or legal separation from a covered employee – Divorce or legal separation date: ______________
- ☐ Death of a covered employee
- ☐ Covered dependent child no longer meets eligibility requirements – Date of event: ______________

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.: ______________

NOTE: To qualify for a premium subsidy under the Stimulus Bill you must complete the subsidy request form and submit it for approval.

SECTION 3 DEPENDENTS CONTINUING COVERAGE

Please list all dependent family members continuing coverage.

LAST NAME FIRST M.I.	DATE OF BIRTH	SEX	RELATIONSHIP	LAST NAME FIRST M.I.	DATE OF BIRTH	SEX	RELATIONSHIP

SECTION 4 SWITCHING PLANS (for subsidized premium only, as allowed by the employer)

Old plan:	**New plan:**

The option to switch plans is only available to individuals who are eligible for subsidized premium under the Stimulus Bill. The switch must be allowed by the employer and you can only switch to a plan that is of an equal or lower cost and is currently offered to other individuals on the employer's group plan. The change in plans will apply to all individuals enrolling in continuation coverage on this election form.

SECTION 5 SIGNATURE OF QUALIFYING INDIVIDUAL

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long-term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for this information.

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.providence.org/healthplans** or by calling Customer Service.

To the best of my knowledge, the above is correct and I understand that if I provide false information, the Health Plan can recover payment(s) made, cancel my membership, and/or refuse to pay claims. In addition, I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage in Section 3 above) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

SIGNATURE: ______________ DATE: ______________