Small Group Plans enrollment application and change form

Samaritan Health Plans

Please complete all information on this form. This information is required to process your enrollment/termination request.
PO Box 1310, Corvallis, OR 97330 • **800-832-4580** • Fax 541-768-9778 • SHPOCommercialGroups@samhealth.org • **samhealthplans.org**

Employer group name: _____ Group number: _____ Class ID: _____ Date of hire: _____

Requested effective/termination date: _____ Member ID: _____

☐ Open enrollment. ☐ New enrollment. ☐ New hire. ☐ Change in status. ☐ Dependent add. ☐ Waiving coverage. ☐ Termination. ☐ Other: _____

Reason for termination or change (marriage, divorce, dependent change, etc.): _____ Date of event: _____

Qualifying event (subscriber termination only): _____ ☐ COBRA (20+ employees). COBRA start date: _____ COBRA end date: _____

Plan selection: _____ ☐ Plan description. _____ ☐ Plan description. _____

☐ Plan description. _____

Employee information

First name: _____ Middle initial: _____ Last name: _____

☐ Single. ☐ Married. ☐ Domestic partnership. DOB: _____ SSN: _____ Gender: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Cell phone: _____ Email: _____

Preferred spoken language: _____ Preferred written language: _____

Primary care physician: _____ Is this your current PCP? ☐ Yes. ☐ No.

Dependent information (If waiving, see next page.)

Add	Drop	First name	Middle initial	Last name	Relationship to employee	Social Security number	Date of birth	Gender
☐	☐							
☐	☐							
☐	☐							
☐	☐							

Additional coverage information (This section is not a waiver of coverage. This information is required for payment of claims.)

Do you or your family members have any additional health insurance and/or Medicare? ☐ Yes. ☐ No. Insurance Carrier: _____

If yes, please check the types of coverage and then complete the information below. ☐ Medical. ☐ Prescription drug. ☐ Vision.

Policyholder name: _____ Policyholder's date of birth: _____

Policy number: _____ Carrier phone number: _____ Policy effective date: _____

Full names of persons covered: _____

Is the insurance of any above dependents affected by a divorce decree/court order? ☐ Yes. ☐ No.
If yes, please include portion of decree that shows responsibility for medical expenses.

Accuracy of information: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in this application for insurance may be guilty of a crime and may be subject to civil fines and penalties. Samaritan Health Plans may cancel such person's membership and refuse to pay their claims.

Employee acknowledgment: I acknowledge and understand that coverage under Samaritan Health Plans is determined by the group contract entered into with my employer and is subject to the terms and conditions of such contract. I agree to the eligibility criteria established by my employer and I understand that coverage does not start for me, or any dependent, until all eligibility requirements are satisfied. I further acknowledge and understand that Samaritan Health Plans 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 Samaritan Health Plans; (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 Samaritan Health Plans is restricted to circumstances in which the patient has provided a signed authorization.

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).

Employee signature: _____ Date: _____

or

Administrator signature: _____ Date: _____

Declination of coverage

I am declining coverage for: ☐ Myself. ☐ My spouse/domestic partner. ☐ My dependent children. ☐ Myself and my dependents.

Reason medical coverage is being declined (required if declining coverage):

☐ I have qualifying medical coverage through: Name of insurance carrier: _____
Type of coverage: ☐ Other employer. ☐ Spouse/domestic partner's employer. ☐ Parent's employer. ☐ Medicare. ☐ Medicaid. ☐ Tricare. ☐ Indian Health Service.

☐ I have other medical coverage through individual policy. Are you an American Indian or Alaskan Native? ☐ Yes. ☐ No.

☐ I do not have other medical coverage and I am not enrolling (please explain): _____

I hereby decline coverage in the group plan offered by my employer as indicated above. I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Employee signature: _____ Date: _____

Race/ethnicity

The following questions will help us to better serve all communities. These questions are optional.
Which of the following describes your racial or ethnic identity? Please check all that apply.

Member name: _____

Asian
- ☐ Asian Indian.
- ☐ Cambodian.
- ☐ Chinese.
- ☐ Communities of Myanmar.
- ☐ Filipino/a.
- ☐ Hmong.
- ☐ Japanese.
- ☐ Korean.
- ☐ Laotian.
- ☐ South Asian.
- ☐ Vietnamese.
- ☐ Other Asian.

American Indian or Alaska Native
- ☐ American Indian.
- ☐ Alaska Native.
- ☐ Canadian Inuit, Metis, or First Nation.
- ☐ Indigenous Mexican, Central American, or South American.

Hispanic or 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.

Middle Eastern or North African
- ☐ Middle Eastern.
- ☐ North African.

White
- ☐ Caucasian/White (no national affiliation).
- ☐ Eastern European.
- ☐ Western European.
- ☐ Other White (African, Australian, New Zealand descent).
- ☐ Slavic.

Black or African American
- ☐ African American.
- ☐ Afro-Caribbean.
- ☐ Ethiopian.
- ☐ Somali.
- ☐ Other African (Black).
- ☐ Afro-Latinx/Bi-racial/Other.
- ☐ Other Black.

Other
- ☐ Other.
- ☐ Don't know.
- ☐ Don't want to answer.

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.
- ☐ Koreanrabic.
- ☐ Decline/Unknown.
- ☐ Other.

Contact information

For more information about your plan benefits, please contact customer service at **800-832-4580** (TTY **800-735-2900**).