MEMBER ENROLLMENT & CHANGE FORM

SMALL GROUP EMPLOYEES IN OREGON

Please complete all information on this form. This information is required to process your enrollment.

GROUP INFORMATION

Employer group name:	Group number:
Requested effective date:	Date of hire:

ENROLLMENT, CHANGE OF STATUS OR WAIVING COVERAGE

❑ New Enrollment	❑ Open Enrollment	❑ Change in existing status	❑ Waiving coverage
Date of change event:	Effective date for waiving coverage:	Member ID number:	
Reason for status change (marriage, divorce, dependent change, etc.):			
❑ State continuation (<19 employees)		❑ COBRA (20>employees)	
(IF ON COBRA) Original start date:		Maximum period end date:	

EMPLOYEE INFORMATION

Last name:	First name:	Middle initial:	❑ Mr. ❑ Mrs. ❑ Ms.
Birth date (mm/dd/yyyy):	Sex: ❑ Male ❑ Female	Social security number: _ _ _ - _ _ - _ _ _ _	
Permanent street address:			County:
City:	State: , Oregon	Zip:	
Mailing address:			
City:	State: , Oregon	Zip:	
Home phone:	Work phone:	Email address:	

PLAN CHOICE

❑ Samaritan Oregon Standard Bronze	❑ Samaritan Oregon Standard Silver
❑ Samaritan Health & Wellbeing 5000/60	❑ Samaritan Health & Wellbeing 2500/20
❑ Samaritan Health & Wellbeing 3000/20	❑ Samaritan New Performance PPO
❑ Samaritan Alternative Care Rider $15 (Non-standard plans ONLY)	❑ Samaritan Alternative Care Rider $25 (Non-standard plans ONLY)
❑ Samaritan Vision Plan	

Samaritan Health Plans • Enrollment Department • 2300 NW Walnut Blvd. • Corvallis, OR 97330
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DEPENDENT INFORMATION

Add	Drop	First name	Last name	Middle initial	Relationship to employee	Social security number	Birth date	Gender (m/f)
❑	❑							
❑	❑							
❑	❑							
❑	❑							
❑	❑							

OTHER COVERAGE INFORMATION

Do you or your family members have any additional health insurance and/or Medicare? ❑ Yes ❑ No

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

Policyholder name:	Policyholder birth date:	
Insurance carrier:	Policy number:	Effective date of policy:
Carrier phone number:	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.

Do you or any family members listed on this application have a Certificate of Creditable Coverage? ❑ Yes ❑ No

If yes, please complete the Other Coverage Information above and attach a copy of your Certificate of Creditable Coverage with this application.

This application cannot be processed until notification is received that the group coverage has been terminated.

STATEMENT AND SIGNATURE

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.

Subscriber acknowledgement: I acknowledge and understand that Samaritan Health Plans may request or disclose health information, other than psychotherapy notes, about me or my dependents (person 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 of 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.)

Signature:	Date: