MEMBER ENROLLMENT & CHANGE FORM

FOR LARGE GROUP EMPLOYEES IN OREGON

Samaritan Health Plans

Please complete all information on this form. This information is required to process your enrollment, status change or waiving coverage.

GROUP INFORMATION

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

ENROLLMENT, CHANGE OF STATUS OR WAIVING COVERAGE

❑ New enrollment ❑ Open enrollment ❑ New hire ❑ Dependent add ❑ Late enrollee ❑ Waiving coverage ❑ Other

Life event date:	Effective date for waiving coverage:	Member ID number:

Reason for status change (marriage, divorce, dependent change, etc.):

COBRA

❑ COBRA (20> employees)

(IF ON COBRA) Original start date:	Maximum period end date:

EMPLOYEE INFORMATION

Last name:	First name:	Middle initial:	❑ Mr. ❑ Mrs. ❑ Ms.

Marital status: ❑ Single ❑ Married ❑ Domestic partnership

Birth date (mm/dd/yyyy):	Gender: ❑ Male ❑ Female	Social security number: _ _ _ - _ _ - _ _ _ _

Permanent street address:	County:

City:	State:	Zip:

Mailing address (if different than above):

City:	State:	Zip:
Home/cell phone:	Work phone:	Email:

PLAN CHOICE

❑ Samaritan Everyday Choices Option 1 ❑ _____ ❑ _____ ❑ _____	❑ Samaritan Everyday Choices Option 2 ❑ _____ ❑ _____ ❑ _____
❑ Samaritan Everyday Choices Basic ❑ _____ ❑ _____ ❑ _____	❑ Samaritan Vision Plan Benefits
❑ Samaritan HSA 2500	❑ Samaritan HSA 5250

Samaritan Health Plans • Enrollment Department • 2300 NW Walnut Blvd. • Corvallis, OR 97330
SHPOCommercialGroups@samhealth.org • 1-800-832-4580 • Fax: 541-768-9937 • samhealthplans.org

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:	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.

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:

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DECLINATION OF COVERAGE INFORMATION

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 (provide carrier name and check coverage type):
Name of insurance carrier: _____
Type of coverage: ❑ My other employer ❑ My spouse's/domestic partner's employer ❑ My 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 am not enrolling because (please explain): _____

STATEMENT OF DECLINATION OF COVERAGE

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.

Signature:	Date:

FOR SAMARITAN USE ONLY

Effective date of coverage:	Payment received:

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