Enrollment / Termination / Change of Status / Waiver

Samaritan Health Plans

P.O. Box 1310, Corvallis, OR 97330 · 800-832-4580 · Fax 541-768-9778 · SHPOCommercialGroups@samhealth.org · samhealthplans.org

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

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 status change (marriage, divorce, dependent change, etc.) or waiving coverage:			Date of event:
Qualifying Event (subscriber termination only):	❑ COBRA (20+ employees)	COBRA start date:	COBRA end date:

Deductible / Co-pay

❑ Standard Bronze ❑ Standard Silver ❑ Performance

Employee Information

Last name:	First name:	Middle initial:	
❑ Single ❑ Married ❑ Domestic partnership			
Mailing address:			
City:	State:	Zip:	
Home phone:	Work phone:	Email:	

Subscriber/Dependent Information *(If waiving, see next page.)*

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

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

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

Insurance Carrier:

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.

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

If yes, please complete the other coverage information above and attach a copy of your Certification of Credible Coverage with this application.

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 the 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 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: _____

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 (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 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.

Signature: _____ Date: _____