



Task Force on Universal Health Care Consumer Advisory Committee Interest Form

Start of Block: Default Question Block

This is an application for the Consumer Advisory Council of the SB 770 Task Force on Universal Health Care. Please complete this application before September 4, 2020. Please contact LPRO staff at 503-986-1520 or 503-986-1509 if you have any questions.

Full name:

Address:

City:

State:

Zip code:

Cell phone:

Email address:

End of Block: Default Question Block

Start of Block: Block 2

I currently have health coverage through:

- ☐ PEBB/OEBB
 - ☐ Employer-sponsored insurance
 - ☐ Commercial insurance without employer contribution
 - ☐ Medicaid
 - ☐ Medicare
 - ☐ Federal Employees Health Benefit Program
 - ☐ TRICARE
 - ☐ Veterans Administration
 - ☐ Indian Health Service
 - ☐ Other (specify): _____
 - ☐ Do not currently have health coverage
-

Are you a parent or guardian of a child enrolled in the Children's Health Insurance Program?

- ☐ Yes
- ☐ No
- ☐ Choose not to respond

End of Block: Block 2

Start of Block: Supplemental questions

Why would you like to serve on this advisory committee?

Please briefly describe any experience or expertise you have with seeking or receiving health care in Oregon to address serious medical conditions or disabilities.

If you are selected to serve, what are the opportunities you see for this advisory committee to inform the design of a universal health care system for Oregon?

End of Block: Supplemental questions

Start of Block: Please type your full name and today's date to sign this application.

Please type your full name and today's date to sign this application.

Full name:

Today's date:

End of Block: Please type your full name and today's date to sign this application.
