Individual and Family Plans

2017 Policy Change Request

PROVIDENCE Health Plan

Please note: Does not apply to plans purchased through the Marketplace. Please contact the Marketplace at 1-800-318-2596.

Thank you for continuing your individual health plan coverage with Providence Health Plan (PHP). Please visit www.ProvidenceHealthPlan.com for additional information about your health plan choices and premium information.

INSTRUCTIONS AND INFORMATION

This Policy Change Request form is for the policyholder requesting one or more of the following changes. Please check the box(es) to indicate your change(s). Submit the pages noted after the type of change.

- ☐ Cancel a policy (pages 1 & 4)
- ☐ Remove a dependent - spouse and/or child(ren) (pages 1& 4)
- ☐ Add a dependent - spouse and/or child(ren) (pages 1, 2, 3, 4)
- ☐ Name change (pages 1, 3, 4)
- ☐ Date of birth correction (pages 1, 3, 4)
- ☐ Update tobacco usage (pages 1, 3, 4)

The effective date of the policy change will be the first of the month following receipt of this form, except as indicated to cancel a policy or add a newborn/adopted child(ren).

Please complete the Member Information section first for all requests. Please PRINT CLEARLY and provide complete information. Incomplete information may delay your effective date. Complete only the section(s) that apply to your specific request.

Member Information			
Name		Current PHP Individual & Family Plan ID Number	
Residence Address		Mailing Address	
City	State	Zip Code	County
Home Phone Number	Work Phone/Other Phone Number	E-mail Address	

CANCEL A POLICY:

I wish to terminate my coverage in the above PHP Individual & Family plan *(please initial)* _____

(Termination of coverage will be effective on the last day of the monthly period through which premium was paid at the time this form is received by PHP.)

REMOVE A DEPENDENT FROM THE POLICY:

List all Individual or Family Member(s) to be Removed from Policy by Policyholder only (Please include full, legal names.)

Name Last	First Name, Middle Initial	Gender	Date of Birth (Mo-Day-Yr)	Social Security Number	Residence Zip Code and County
1. Spouse ☐or Domestic Partner ☐ (check one)		☐ Male ☐ Female	/ /		
2. Dependent Child		☐ Male ☐ Female	/ /		
3. Dependent Child		☐ Male ☐ Female	/ /		
Please explain your relationship to any person listed above whose last name is different than yours:					

ADD A DEPENDENT:

Special Enrollment Qualifying Event section must be completed if this form is submitted Feb. 1 through Dec. 31, 2017.

☐ Add spouse or domestic partner*

☐ Add child (age 20 and younger) to a dependent-only policy

☐ Add dependent (age 25 and younger to a family policy)

☐ Add newborn (within 60 days of birth)

☐ Add adopted child (within 60 days of placement)

Date of birth: ____/____/____ Date of placement: ____/____/____ **Effective date: ____/____/____

*A Domestic Partner must be a member of the applicant's same sex, at least 18 years of age and must have legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.

**Effective date requested other than date of birth or placement.

List all Individual or Family Member(s) to be Added to Policy (Please include full, legal names.)					
Name Last	**First Name, Middle Initial**	**Gender**	**Date of Birth (Mo-Day-Yr)**	**Social Security Number**	**Residence Zip Code and County**
1. Spouse ☐or Domestic Partner ☐ (check one)		☐ Male ☐ Female	/ /		
2. Dependent Child		☐ Male ☐ Female	/ /		
3. Dependent Child		☐ Male ☐ Female	/ /		
Please explain your relationship to any person listed above whose last name is different than yours:					

1. Does anyone listed above use tobacco? (Tobacco use is defined as the use of tobacco products in any form an average of four or more times per week within the past six months.)

☐ Yes ☐ No

1a. If Yes, list name and type of product:

Name _____ Type of product _____

Name _____ Type of product _____

Name _____ Type of product _____

Please note: Our Standard plan options DO NOT include pediatric dental coverage. Under the health care reform law (the Affordable Care Act or ACA), if you purchase our medical coverage outside of the Marketplace, we must have reasonable assurance that you have obtained separate pediatric dental coverage through a Marketplace-certified pediatric dental plan. This requirement applies whether you obtain coverage for children or adults. Marketplace-certified pediatric dental plans can be found through the Federal Health Insurance Marketplace, www.healthcare.gov.

UPDATE TOBACCO USAGE:

Has any person on this application used tobacco products in any form on an average of four or more times per week **within the last 6 months?**

☐ Yes ☐ No

If Yes:

Name _____ Type of product _____

Name _____ Type of product _____

Name _____ Type of product _____

SPECIAL ENROLLMENT QUALIFYING EVENTS:

Complete this section only if you are applying outside of open enrollment (Feb. 1, 2017 - Dec. 31, 2017)
If you are adding a dependent outside of Open Enrollment due to a Special Enrollment Qualifying Event, you must complete your policy request form within 60 days of your qualifying event or your loss of coverage, whichever is later. Please indicate the date of your event in the chart below. No effective dates prior to the date of application submission are allowed.

Qualifying Event	Date of Event
Marriage or Registered Domestic Partnership	
Loss of coverage due to end of Marriage or Registered Domestic Partnership	
Birth, Adoption or Placement for adoption or Foster care of a child	
Acquired legal guardianship	
Loss of coverage as dependent due to age	
Involuntary loss of coverage except failure to pay the premium	
Involuntary termination of COBRA coverage	
Qualified Medical Child Support Order (QMCSO)	
Lose or become eligible for state premium assistance under Medicaid or CHIP program	
No longer residing in the service area	
Survivor of domestic abuse/violence or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner	

NAME CHANGE or DATE OF BIRTH CORRECTION:

Please complete for each person on the policy whose name needs to be changed
(Use separate sheet if needed.)

Last Name	First Name, Middle Initial	Gender	Date of Birth (Mo-Day-Yr)	Effective Date
1. On current policy	On current policy	☐ Male ☐ Female	/ /	
Change to	Change to			
2. On current policy	On current policy	☐ Male ☐ Female	/ /	
Change to	Change to			

Certification and Authorization

Certification Statement

I affirm that I am requesting the aforementioned changes in this Policy Change Form as policyholder, and that the answers given in this Policy Change Form are complete and correct. I am providing these answers as part of the procedure required by Providence Health Plan (PHP) to change my status to policyholder and/or to request a change in coverage. I understand that it is my responsibility to notify PHP of any changes in to my previously submitted health statement(s). If I fail to disclose this information to PHP, if this request contains any material misstatements or omissions, PHP may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. I will promptly inform PHP in writing if anything happens before my coverage takes effect that makes this change request incomplete or incorrect. I understand and agree that no change in coverage shall be in force until the effective date determined by PHP and that PHP may contact me to clarify this request. As the policyholder, I understand I have the right to inspect the information in my file.

Authorization for the Release and Use and Disclosure of Personal Health Information

I authorize any physician, healthcare provider, hospital, insurance or reinsurance company, or other insurance information exchange service to disclose to Providence Health Plan (PHP) or its representatives personal health information relating to me and/or any family members included in this Plan Change Form. Furthermore, I agree to sign any additional forms related to release of personal health information, as needed by PHP to obtain this information. I acknowledge and understand that the health information released to PHP:

- Will only be used for the purpose of determining enrollment in health plan coverage or eligibility for benefits;
- May include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, medication records, dental records, or hospital records (including nursing records and progress notes); and
- May address all medical and mental health conditions and services, including HIV treatment, but shall exclude psychotherapy notes and genetic information.

I understand that I may cancel this authorization at any time by sending a written request to PHP. My cancellation of this authorization will not affect any action PHP took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with PHP. I understand that if I choose not to sign this authorization that PHP will be unable to process my request for change in coverage.

In addition, if I understand that PHP may request and disclose personal health information, other than psychotherapy notes, for the purpose of: (a) performing the health plan business operations of PHP; (b) facilitating health care treatment; (c) issuing or facilitating payment for health care services; or (d) as required by law. The disclosure of psychotherapy notes by PHP is restricted to circumstances in which the patient has provided a signed authorization.

For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available at our website at www.ProvidenceHealthPlan.com or by calling Customer Service.

1. I understand that Providence Health Plan will:
   a) notify me in writing as to the status of my request.
   b) send me a legal contract upon acceptance of my request.
2. I verify that my employer will not be paying the premium on this policy.
3. By signing, I agree to the above conditions.

Print name of Policyholder X _____	Date
Signature of Policyholder X _____	Date

Please email or mail your completed Policy Change Request to:

phpindividualforms@providence.org
Providence Health Plan
P.O. Box 4649
Portland, OR 97208-4649