PROVIDENCE Health Plan

2019 Change Form

If you are not a current Providence Health Plan Individual & Family Policyholder, do not use this form. To complete an application for new enrollment, please visit **ProvidenceHealthPlan.com**.

This form cannot be used to make changes to plans purchased through the Federal Health Insurance Marketplace. Contact the Marketplace at **HealthCare.gov** or by calling 1-800-318-2596.

See Page 6 for Change Form instructions.

I. Policyholder Information

This section must be completed for all plan change and cancellation requests. All fields are required unless marked otherwise.

Subscriber ID Number:

Policyholder Last Name	First Name	MI	Date of Birth

Home Address (no PO box or business) ☐ Check box if new address	City	State	Zip Code	County

Mailing Address (if different from home) ☐ Check box if new address	City	State	Zip Code	County

E-mail Address	Primary Phone Number	Other Phone (optional)

Social Security Number	Sex	Have you used any tobacco products in the last six months?
	☐ Female ☐ Male	Tobacco use is defined as an average of at least four times per week, except for religious or ceremonial purposes. ☐ Yes ☐ No

II. Cancel My 2019 Individual & Family Plan Coverage

This section should only be completed if you want to cancel your coverage.

☐ I want to cancel my 2019 Individual & Family Plan.

This action will end the health insurance coverage for all enrolled members on your plan. Termination of your medical (and dental) coverage will be effective on the last day of the monthly period through which premium was paid at the time this form is received. Sign, date, and submit this page to complete your request to cancel your coverage.

Signature of Policyholder to cancel your coverage (required)	Signature Date (required)

III. Change or Update My 2019 Individual & Family Plan Coverage

Please refer to the Change Form instructions on Page 6 or **ProvidenceHealthPlan.com** for details regarding the effective date of plan changes.

I want to make the following changes to my plan, 1/1/19 – 12/31/19.

- ☐ Remove dependent(s)
- ☐ Report changes or corrections to a plan member's personal information (i.e. name, date of birth, tobacco status)
- ☐ Remove dental coverage
- ☐ Report a new address within the same service area. Please refer to the benefit plan chart on page 3.
  - Date of your move (required):

I want to make changes to my plan during a Special Enrollment Period (SEP), 1/1/19 – 12/31/19.

☐ Change my medical plan ☐ Add dependent(s) ☐ Add dental coverage

Providence Health Plan (PHP) must receive your completed Change Form and required documentation within 60 days of your Qualifying Event. Refer to the Change Form instructions or **ProvidenceHealthPlan.com** for additional information regarding SEPs.

Date of Qualifying Event (required):	
Provide the name of the family member who has experienced the Qualifying Event (required):	

Select your or your eligible family dependent's Qualifying Event:

- ☐ Marriage or domestic partnership*
- ☐ Birth, adoption, or placement for adoption or foster care of a child
- ☐ Qualified Medical Child Support Order (QMCSO)
- ☐ Acquired legal guardianship
- ☐ Permanent move to a new PHP service area that offers different health plan options
- ☐ Loss of coverage as a dependent due to age
- ☐ Loss of coverage due to end of marriage or domestic partnership*
- ☐ Involuntary loss of coverage except for failure to pay the premium
- ☐ Involuntary loss of Medicaid or CHIP coverage
- ☐ Newly eligible for a state or federal – sponsored premium assistance program
- ☐ Loss of Advance Premium Tax Credit (APTC) or Cost Sharing Reductions (CSR)
- ☐ Survivor of domestic abuse or spousal abandonment
- ☐ Denial of Medicaid or CHIP eligibility determined after open enrollment ended or more than 60 days after a qualifying event.

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

IV. 2019 Medical Plan Selection

To make the following changes to your medical plan, check <u>one</u> box below. If there are no changes, do not complete this section.

Connect Network	Service Areas
☐ Connect 2500 Silver	Clackamas, Hood River, Multnomah, Washington, Yamhill (zip code 97132 only)
☐ Connect 7900 Bronze	

Choice Network	Service Areas
☐ Providence Oregon Standard Gold- Choice	Benton, Clackamas, Clatsop, Crook, Deschutes, Douglas, Hood River, Jackson, Jefferson, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Washington, Yamhill
☐ Providence Oregon Standard Silver- Choice	
☐ Providence Oregon Standard Bronze- Choice	
☐ HSA Qualified 6650 Bronze- Choice	

Signature Network	Service Areas
☐ Providence Oregon Standard Gold- Signature	Baker, Columbia, Coos, Curry, Gilliam, Grant, Harney, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler
☐ Providence Oregon Standard Silver- Signature	
☐ Providence Oregon Standard Bronze- Signature	
☐ HSA Qualified 6650 Bronze- Signature	

V. 2019 Dental Plan Selection

To make the following changes to your dental plan, check <u>one</u> box below. If there are no changes, do not complete this section.

Dental Coverage	Service Areas
☐ Opt In: Providence Progressive Dental Coverage	All counties in Oregon
☐ Opt Out: No Providence Progressive Dental Coverage	

To review a Summary of Benefits and Coverage (SBC) for these medical plans, visit **ProvidenceHealthPlan.com/sbc**.
If you select a Connect or Choice Network plan, you will need to choose a medical home and a primary care provider upon enrollment. To see medical homes in your area, view our provider directory at **ProvidenceHealthPlan.com/findaprovider**.

Providence Progressive Dental Plan: In order to purchase the Providence Progressive Dental Plan, you must also purchase a PHP medical plan. If you choose the Providence Progressive Dental Plan, all people on the plan will be enrolled. There is a separate premium for the dental plan which will apply to each person on the policy. For children age 18 and younger who are enrolled on the Connect plans, this coverage will be supplemental to the pediatric dental coverage already included under the medical plan.

Pediatric Dental Disclaimer: Our Standard and HSA medical plans DO NOT include pediatric dental coverage. Under the health care reform law (the Affordable Care Act or ACA), if you purchase one of these plans 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 at HealthCare.gov.

V. Change or Update My Dependent Information

Include full, legal names. For a child-only plan, children must be age 20 and younger as of their effective date. For all other plans, children must be age 25 and younger as of their effective date. If there are no changes, do not complete this section.

Check One	Relationship to Policyholder
☐ Add ☐ Remove ☐ Update	

Last Name	First Name	MI	Date of Birth

Social Security Number	Sex	Does this dependent use any tobacco products?
	☐ Female ☐ Male	Tobacco use is defined as an average of at least four times per week, except for religious or ceremonial purposes. ☐ Yes ☐ No

Home Address (no PO box or business)	City	State	Zip Code	County
☐ Check if different from policyholder's address				

Check One	Relationship to Policyholder
☐ Add ☐ Remove ☐ Update	

Last Name	First Name	MI	Date of Birth

Social Security Number	Sex	Does this dependent use any tobacco products?
	☐ Female ☐ Male	Tobacco use is defined as an average of at least four times per week, except for religious or ceremonial purposes. ☐ Yes ☐ No

Home Address (no PO box or business)	City	State	Zip Code	County
☐ Check if different from policyholder's address				

Check One	Relationship to Policyholder
☐ Add ☐ Remove ☐ Update	

Last Name	First Name	MI	Date of Birth

Social Security Number	Sex	Does this dependent use any tobacco products?
	☐ Female ☐ Male	Tobacco use is defined as an average of at least four times per week, except for religious or ceremonial purposes. ☐ Yes ☐ No

Home Address (no PO box or business)	City	State	Zip Code	County
☐ Check if different from policyholder's address				

VI. Read, Sign, & Submit

Certification of Completion and Correctness

I affirm that I am requesting a change in coverage for myself and/or my family dependent(s) and that the answers given in this Change Form are complete and correct. I am providing these answers as part of the procedure required by Providence Health Plan (PHP) to request a change in my insurance coverage. 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 a member, I understand I have the right to inspect the information in my file. I understand that I can visit **ProvidenceHealthPlan.com** to educate myself about PHP's privacy practices. I understand that I can get a copy of PHP's Notice of Privacy Practices by calling Customer Service at 503-574-7500.

Signature

1. I understand that this is an individual health insurance contract and I verify that neither my employer nor any third party will be paying the premium on this policy except as permitted by state or federal regulation.
2. I am the parent or legal guardian of all dependent children listed on this Change Form.
3. I verify that the home address(es) I provided on this Change Form for myself and my dependents are accurate.
4. I understand that I must update my information with Providence Health Plan if anything changes.
5. I verify that any newly enrolled dependent(s) are not entitled to Medicare Part A and/or enrolled in Medicare Part B. (The federal government does not allow health plans to issue individual coverage that duplicates coverage available through Medicare.)
6. I affirm that if I choose a medical plan without pediatric dental coverage, I will obtain pediatric dental coverage through a separate Marketplace-certified pediatric dental plan, and that I will notify Providence Health Plan if I do not obtain coverage.

By signing, I agree to the above conditions.

Signature of Policyholder (required)	Signature Date (required)

Print Name of Policyholder

VII. Change Form Instructions

If you have experienced a Qualifying Event or need to update or correct any information outside of the Open Enrollment period, you may complete this paper form or our online change form to request changes to your 2019 Individual & Family Plan coverage. For an online change form, visit **ProvidenceHealthPlan.com.**

Who can make changes?

Changes to your Providence Health Plan coverage can only be requested by the Policyholder.

Changes and effective dates

This form is for changes effective 1/1/19 – 12/31/19.

This form may be used with a Qualifying Event to:

- Change your medical plan
- Add dependent(s)
- Add Providence Progressive Dental coverage
- Report a change of address to a new service area (change of medical plan required)

This form may also be used to:

- Cancel your medical and/or dental plan. Termination of your medical (and dental) coverage will be effective on the last day of the monthly period though which premium was paid at the time this form is received.
- Remove dependent(s)
- Report a change of address within your current service area
- Report changes or corrections to a plan member's personal information (i.e. name, date of birth, tobacco status)

For all qualifying events and changes, coverage will be effective the first day of the month according to the effective dates table below provided your completed change form is received within 60 days of the qualifying event.
NOTE: If the qualifying event is birth, adoption, placement for adoption or foster care of a child, or a court order, coverage will be effective from the date of the event. If you would prefer a regular prospective effective date based on the table below, please clearly indicate this on your change form.

For further instructions and details related to a Special Enrollment Period, visit **ProvidenceHealthPlan.com**.

Date Change Form is Received	Effective Date of Change
1st to 15th of the month	1st day of the following month
16th to the last day of the month	1st day of the second following month

How to submit?

Submit your completed Change Form by:

E-mail to: phpindividualforms@providence.org OR Mail to: Providence Health Plan
P.O. Box 4649
Portland, OR 97208-4649

If your Change Form is incomplete (missing Policyholder information, valid signature, signature date, qualifying event, qualifying event date, etc.) or if additional information is required, this may delay or void your requested changes. Your Change Form will expire 60 days after the signature date.

What's next?

If applicable, Providence Health Plan will send you an invoice with your updated premium rate after your requested changes have been processed. Providence Health Plan recommends that you keep a copy of your completed Change Form for your records.

Need help?

For a glossary of terms, visit **ProvidenceHealthPlan.com/glossary** for a listing of health insurance terms and definitions. For more information or for assistance completing this Change Form, contact Membership Accounting at 503-574-5791 or 888-816-1300, TTY: 711 or your insurance producer.

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN