PROVIDENCE Health Plan

2021 Washington Individual & Family Open Enrollment Change Form

This form is for **Open Enrollment (November 1 through December 15, 2020)** changes only.

Don't use this form if you purchased your plan through the **Washington Health Bene it Exchange (WAHBE)** — you'll need to contact WAHBE at **WaHealthPlanFinder.org** or by calling 1-855-923-4633.

Things to Keep in Mind

This form can be used to:

+ Update Policyholder information
+ Change your medical plan
+ Add, remove or update dependent information
+ Cancel your health plan coverage

Submission options:

+ Submit **pages 1–4** to request additional renewal changes.
+ Submit **only page 1** (the next page) to cancel your health plan coverage effective December 31, 2020.

Changes and effective dates:

Any change requests we receive during Open Enrollment **(November 1 through December 15, 2020)** will take effect January 1, 2021. Change forms we receive after **December 15, 2020** won't be processed.

Remember to double-check your answers after you've finished filling everything out.

If this form is incomplete for any reason—if it's missing a signature, date of signature, date, or any other required information—it could delay or invalidate your requested change(s).

Need some extra help? We know health insurance can be confusing, so we put together resources for you to learn about different plans, compare coverage options and check rates at **ProvidenceHealthPlan.com**. If you need help completing this form, contact your Insurance Agent/Producer or the Providence Health Plan Membership Accounting team at 503-574-5791 or 1-888-816-1300 (TTY: 711), Monday through Friday, 8 a.m. to 5 p.m. PST.

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

Policyholder Information

This section needs to be completed for all plan change and cancellation requests.
If this information is incomplete, your Change Form may be returned causing a delay.

LAST _____ FIRST _____ MI _____ BIRTHDATE (MM/DD/YY) __ __/__ __/__ __

SUBSCRIBER ID NUMBER _____ SOCIAL SECURITY NUMBER _____

SEX (CHECK ONE) ☐ Male ☐ Female

PHYSICAL ADDRESS (NO P.O. BOX OR RETAIL/BUSINESS ADDRESSES) _____ ☐ This is a new address

CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS) _____ ☐ This is a new address

CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

HOME/CELL PHONE _____ WORK/OTHER PHONE (OPTIONAL) _____ EMAIL ADDRESS _____

Have you used any tobacco products in the last 6 months? ☐ Yes ☐ No
(Tobacco use is defined as an average of at least four times a week, except for religious or ceremonial purposes.)

Option 1: Cancellation

Complete this section only if you want to cancel your Individual & Family Plan coverage.

☐ **I want to cancel my Individual & Family Plan coverage effective Dec. 31, 2020.**

Checking this box will end the health insurance coverage for all enrolled members on your plan, and you and your dependents won't be enrolled for 2021. To get new coverage outside of the Open Enrollment period (Nov. 1–Dec. 15), you need to have a qualifying event for a Special Enrollment Period.

Sign, date, and submit only this page to cancel your coverage effective Dec. 31, 2020.

Signature is considered valid only if it is handwritten ("wet") or e-signed with approved third-party software. A copy of legal guardianship or power of attorney must accompany this form if not signed by the Policyholder.

SIGNATURE OF POLICYHOLDER, LEGAL GUARDIAN OR POWER OF ATTORNEY _____ __ __/__ __/__ __ TODAY'S DATE

Option 2: Change Your 2021 Coverage

Open Enrollment is your opportunity to make changes to your current health plan coverage. The changes you request will become effective January 1, 2021 as long as we receive this completed form by December 15, 2020 and timely payment of your November and December premiums.

> You can learn more about each of the medical plans listed here by reading their corresponding Summary of Benefits and Coverage (SBC) materials at **ProvidenceHealthPlan.com/sbc**.

Choose a New Medical Plan

Applicable Counties	Network	Plan (Check One)
Clark, Benton, Franklin, Spokane, Thurston, Walla Walla	Choice	☐ Columbia 1500 Gold
		☐ Columbia 4500 Silver
		☐ Columbia 8550 Bronze
		☐ Providence Cascade Gold
		☐ Providence Cascade Silver
		☐ Providence Cascade Bronze

> You'll need to choose a Medical Home and a primary care provider (PCP) when you enroll. To choose from a list of available medical homes, PCPs and doctors in your area, visit **ProvidenceHealthPlan.com/findaprovider**.

Change Information for My Dependents

Only changes reflected on this form will be updated on your plan. If you are not making any changes, leave this page blank. Make sure you use full, legal names. Dependent children must be age 25 or younger as of their effective date. If you have additional family members to be enrolled, please include them on a separate sheet with this change form. **If any dependents don't reside at the Policyholder's physical address, you need to provide their physical address below.**

1

CHECK ONE: ☐ Add ☐ Remove ☐ Update

LAST NAME _____ FIRST NAME, MI _____ SSN _____

RELATION TO YOU: ☐ Spouse ☐ Domestic Partner* ☐ Other: _____

___/___/___ BIRTHDATE

SEX: ☐ M ☐ F LIVES WITH POLICYHOLDER? ☐ Yes ☐ No USES TOBACCO?** ☐ Yes ☐ No

2

CHECK ONE: ☐ Add ☐ Remove ☐ Update

LAST NAME _____ FIRST NAME, MI _____ SSN _____

RELATION TO YOU: ☐ Spouse ☐ Domestic Partner* ☐ Other: _____

___/___/___ BIRTHDATE

SEX: ☐ M ☐ F LIVES WITH POLICYHOLDER? ☐ Yes ☐ No USES TOBACCO?** ☐ Yes ☐ No

3

CHECK ONE: ☐ Add ☐ Remove ☐ Update

LAST NAME _____ FIRST NAME, MI _____ SSN _____

RELATION TO YOU: ☐ Spouse ☐ Domestic Partner* ☐ Other: _____

___/___/___ BIRTHDATE

SEX: ☐ M ☐ F LIVES WITH POLICYHOLDER? ☐ Yes ☐ No USES TOBACCO?** ☐ Yes ☐ No

4

CHECK ONE: ☐ Add ☐ Remove ☐ Update

LAST NAME _____ FIRST NAME, MI _____ SSN _____

RELATION TO YOU: ☐ Spouse ☐ Domestic Partner* ☐ Other: _____

___/___/___ BIRTHDATE

SEX: ☐ M ☐ F LIVES WITH POLICYHOLDER? ☐ Yes ☐ No USES TOBACCO?** ☐ Yes ☐ No

*A Domestic Partner must be at least 18 years of age. They must be a member of the Policyholder's same sex, unless one of the partners is at least 62 years of age, and they must have legally entered into a State Registered Domestic Partnership and obtained a Certificate of State Registered Domestic Partnership in accordance with Washington state law.

**Tobacco use is defined as an average of at least four times per week, except for religious or ceremonial purposes.

Dependent(s) Physical Address (if different from Policyholder)

1

DEPENDENT'S LAST NAME _____ DEPENDENT'S FIRST NAME _____ MI _____

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

2

DEPENDENT'S LAST NAME _____ DEPENDENT'S FIRST NAME _____ MI _____

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

Read, Sign & Submit

Certification of Completion and Correctness

I affirm that I am requesting a change in coverage for myself and/or my enrolled family dependents 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 going to **ProvidenceHealthPlan.com** and selecting "Notice of Privacy Practice" or by calling Customer Service at 503-574-7500.

Signature

1. I understand that this is an individual health insurance plan. 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 understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
3. I am the parent or legal guardian of all dependent children listed on this change form.
4. I verify that the physical address I provided on this change form for myself is accurate, as well as any other address provided by me for any dependents.
5. I understand that I must update my information with Providence Health Plan if anything changes.
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. Policyholder signature and date required.

Signature is considered valid only if it is handwritten ("wet") or e-signed with approved third-party software.
A copy of legal guardianship or power of attorney must accompany this form if not signed by the Policyholder.

SIGNATURE

__ __/__ __/__ __
TODAY'S DATE

PRINT NAME

☐ Signed by Policyholder Applicant for Spouse or Domestic Partner

SIGNATURE OF SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)

Submission Options

Mail completed form to:
Providence Health Plan
P.O. Box 4649
Portland, OR 97208-4649

OR

Scan and email completed form to:
phpindividualforms@providence.org

PROVIDENCE Health Plan

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

+ Qualified sign language interpreters
+ Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

+ Qualified interpreters
+ Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

Filing a Grievance

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan
and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-603-2340 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-603-2340 (TTY: 711).

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務. 請致電 1-800-603-2340 (TTY: 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-603-2340 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-603-2340 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-603-2340 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-603-2340 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-603-2340 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-603-2340 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます. 1-800-603-2340 (TTY:711）まで、お電話にてご連絡ください.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-603-2340 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-603-2340 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-603-2340 (رقم هاتف الصم والبكم: TTY: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-603-2340 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-603-2340 (TTY: 711).

ໂປດຊາບ: ຖ້າ ວ່າ ທ່ ານເວ້ ົ າພາສາ ລາວ, ການບ ໍ ລິການຊ່ ວຍເຫຼ ືອ ດ້ ານພາສາ, ໂດຍ ່ ບເສ ັ ຽ ຄ່ າ, ແມ ່ ນມ ີ ພ ້ ອມໃຫ ້ ທ ່ ານ. ໂທຣ 1-800-603-2340 (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-603-2340 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-603-2340 (ATS: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-603-2340 (TTY: 711)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-603-2340 (TTY: 711) تماس بگیرید.