2021 Oregon Individual & Family Change Form

PROVIDENCE Health Plan

This form is for **current Providence Health Plan Individual & Family Policyholders** only and changes to your Providence Health Plan coverage can **only** be requested by the Policyholder. To complete an application for new enrollment, please visit **ProvidenceHealthPlan.com**.

Do not use this form if you purchased your plan through the **Federal Health Insurance Marketplace.** You'll need to contact the Marketplace at **HealthCare.gov** or call 800-318-2596 to request changes to your plan.

To fill out a Change Form online, visit ProvidenceHealthPlan.com.

Keep in mind, some changes require a Qualifying Event (QE).

Experiencing a Qualifying Event grants you a 60-day Special Enrollment Period (SEP) to submit your Change Form. Please see the "Make Changes to Your Plan" section for a list of QE's if the change you want requires one.

Changes that require a QE:

+ Change in medical plan
+ Adding any dependents
+ Adding Providence Progressive Dental Coverage
+ Changing your address after moving to a new service area (Requires a change of medical plan - See the "Applicable Counties" list on page three to determine your service area)

Changes that DO NOT require a QE:

+ Canceling your medical and dental plan
+ Canceling your dental plan only
+ Removing dependent(s)
+ Changing your address after moving within the same service area
+ Reporting changes or corrections to a plan member's personal information (i.e name, birth date, tobacco status etc.)

When will my change(s) go into effect?

This form is for changes effective Jan. 1, 2021–Dec. 31, 2021. For all Qualifying Events and changes, coverage will be effective the first day of the month according to the effective dates table below as long as we receive your completed Change Form **within 60 days** of the Qualifying Event.

DATE WE RECEIVE YOUR CHANGE FORM:	EFFECTIVE DATE OF CHANGE:
1st–15th of the month Example: We receive your Change Form on March 12th.	**1st day of the following month** Example: Your change will be effective on April 1st.
16th–last day of the month Example: We receive your Change Form on March 28th.	**1st day of the 2nd following month** Example: Your change will be effective on May 1st.

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

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 instead prefer a regular prospective (coverage) effective date based on the table above, please clearly indicate this on your form.

Please review the form to check that you've finished filling out all the required sections. If this form is incomplete for any reason—if it's missing Policyholder information, a valid signature, Qualifying Event, 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.

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 (11 DIGITS) _____ 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 _____ 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.**

Checking this box 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 only this page to complete your request to cancel your coverage.

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 (REQUIRED) _____ TODAY’S DATE (REQUIRED) __ __/__ __/__ __

Option 2: Make changes to your 2021 plan

Select one or more changes you want to make to your plan.

I want to make the following changes that don't require a Qualifying Event:

- ☐ Cancel my dental plan only
- ☐ Remove dependent(s)
- ☐ Report changes or corrections to a plan member's personal information (i.e. name, birthdate, tobacco status, etc.)
- ☐ Change my address after moving within the same service area:

  ____ ____/____ ____/____ ____
  DATE OF MOVE (REQUIRED)

If you only have changes that DO NOT require a Qualifying Event, continue to the next page →

I want to make changes after having experienced a Qualifying Event:

- ☐ Change my medical plan
- ☐ Add dependent(s)
- ☐ Change my address after moving to a new service area
- ☐ Add Providence Progressive Dental coverage

Date of Qualifying Event: ____ ____/____ ____/____ ____

Name of family member who experienced the Qualifying Event: _____

Select the Qualifying Event:

- ☐ Involuntary loss of individual or group coverage except for failure to pay the premium
- ☐ Marriage or domestic partnership*
- ☐ Birth, adoption, placement for adoption or foster care of a child
- ☐ Qualfied Medical Child Support Order (QMCSO) or acquisition of 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 Medicaid or CHIP coverage
- ☐ Loss of Advance Premium Tax Credit (APTC) or Cost Sharing Reductions (CSR)
- ☐ Newly eligible for a state- or federal- sponsored premium assistance program
- ☐ Newly gains access to an individual coverage HRA (ICHRA) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Survivor of domestic abuse/violence or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner
- ☐ Denial of Medicaid or CHIP eligibility determined after open enrollment ended or more than 60 days after a qualifying event

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

*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.

Choose a new medical plan:

Changing your medical plan and/or adding a dental plan outside of Open Enrollment requires a Qualifying Event. To make the following changes to your medical plan, check one box below. If there are no changes, leave this section blank.

> 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**.

Applicable Counties	Network	Medical Plan (Check One)
Clackamas, Hood River, Multnomah, Washington, Yamhill (Newberg zip code 97132 only)	Connect*	☐ Connect 1500 Gold ☐ Connect 4500 Silver ☐ Connect 8550 Bronze
Benton, Clackamas, Clatsop, Crook, Deschutes, Douglas, Hood River, Jackson, Jefferson, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Washington, Yamhill	Choice*	☐ Oregon Standard Gold (Choice Network) ☐ Oregon Standard Silver (Choice Network) ☐ Oregon Standard Bronze (Choice Network) ☐ HSA Qualified 7000 Bronze (Choice Network)
Baker, Columbia, Coos, Curry, Gilliam, Grant, Harney, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler	Signature	☐ Oregon Standard Gold (Signature Network) ☐ Oregon Standard Silver (Signature Network) ☐ Oregon Standard Bronze (Signature Network) ☐ HSA Qualified 7000 Bronze (Signature Network)

> *If you choose a Connect or Choice plan, you'll need to choose a Medical Home and a primary care provider (PCP) upon enrollment. To choose from a list of available Medical Homes, PCPs and doctors in your area, visit **ProvidenceHealthPlan.com/findaprovider**.

Add or cancel dental coverage:

In order to purchase a dental plan, you ***must*** purchase one of the medical plans listed above. Providence Progressive Dental coverage is applicable to **all counties.**

Dental Plan (Check One)

☐ **Add** Providence Progressive Dental (Requires a Qualifying Event)	☐ **Cancel** Providence Progressive Dental (Medical coverage will still be in effect)

Things to Know About Our Dental Plan:

+ Everyone on your medical plan will be enrolled, and there's an additional monthly premium of **$32** applied to each covered member on the policy.
+ **For Connect plans:** coverage for children 18 and younger will be supplemental to the pediatric dental coverage already included under the medical plan.
+ For more information about dental benefits and coverage, visit **ProvidenceHealthPlan.com**.

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**.

Change information for dependents:

Only changes reflected on this form will be updated on your plan. If you are not making any changes, leave this page blank. Adding a dependent outside of Open Enrollment requires a Qualifying Event. Make sure you use full, legal names. For a child-only plan, children have to be age 20 or younger as of their effective date. For all other plans, children need to 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 address below.**

1

CHECK ONE: ☐ Add ☐ Remove ☐ Update

LAST NAME _____ FIRST NAME _____ MI _____

BIRTHDATE ___/___/___ SSN _____ RELATION TO YOU* _____

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

2

CHECK ONE: ☐ Add ☐ Remove ☐ Update

LAST NAME _____ FIRST NAME _____ MI _____

BIRTHDATE ___/___/___ SSN _____ RELATION TO YOU* _____

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

3

CHECK ONE: ☐ Add ☐ Remove ☐ Update

LAST NAME _____ FIRST NAME _____ MI _____

BIRTHDATE ___/___/___ SSN _____ RELATION TO YOU* _____

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

4

CHECK ONE: ☐ Add ☐ Remove ☐ Update

LAST NAME _____ FIRST NAME _____ MI _____

BIRTHDATE ___/___/___ SSN _____ RELATION TO YOU* _____

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

*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.

**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 am the parent or legal guardian of all dependent children listed on this Change Form.
3. 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.
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. 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 OF POLICYHOLDER (REQUIRED)

____/____/____
TODAY'S DATE (REQUIRED)

PRINT NAME

☐ Signed by Policyholder 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

To fill out a Change Form online, visit ProvidenceHealthPlan.com.

Have Questions? Call PHP at 503-574-5791 or 888-816-1300 (TTY: 711), Monday through Friday, 8 a.m. to 5 p.m. PST.