

# 2021 Oregon Individual & Family Change Form



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](https://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](https://HealthCare.gov) or call 800-318-2596 to request changes to your plan.

To fill out a Change Form online, visit [ProvidenceHealthPlan.com](https://ProvidenceHealthPlan.com).

## Qualifying Events (QE) are not required to make changes to your health plan during the COVID-19 Special Enrollment Period (Feb. 15th–Aug. 15th, 2021).

You can use this form to:

- + Change your medical plan
- + Add Providence Progressive Dental Coverage
- + Add or remove dependents
- + Cancel your medical and dental plan
- + Cancel your dental plan only
- + Change your address (moving to a new service area requires a change of medical plan - See the "Applicable Counties" list on page 3 to determine your service area)
- + Report 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?

Forms for the COVID-19 Special Enrollment Period must be received by Aug. 15th. Changes will be effective the first day of the month according to the effective dates table below.

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

You may also request an **accelerated effective date** on page 2 ("Option 2: Make changes to your 2021 plan"), which would start on the 1st of the month following our receipt of your completed Change Form.

**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. Your completed Change Form must be received within 60 days of the Qualifying Event.

**Please review the form to check that you've finished filling out all the required sections.** If this form is incomplete for any reason 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.

# 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)
_____	_____	SEX (CHECK ONE)	
SUBSCRIBER ID (11 DIGITS)	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Male	<input type="checkbox"/> Female
_____			<input type="checkbox"/> This is a new address
PHYSICAL ADDRESS (NO P.O. BOX OR RETAIL/BUSINESS ADDRESSES)			
_____	_____	_____	_____
CITY	COUNTY	STATE	ZIP CODE
_____			<input type="checkbox"/> This is a new address
MAILING ADDRESS (IF DIFFERENT FROM PHYSICAL 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 your 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 changes after having experienced a Qualifying Event:

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#### Select the Qualifying Event:

- Birth, adoption, placement for adoption or foster care of a child
- Qualified Medical Child Support Order (QMCSO) or acquisition of legal guardianship

Date of Qualifying Event: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Select the change you want to make:

- Change my medical plan
- Add dependent(s)
- Add Providence Progressive Dental coverage

**Your change(s) will be effective from the date of the Qualifying Event.**

### I want to make changes during the COVID-19 Special Enrollment Period (Feb. 15–Aug. 15, 2021):

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Your change(s) will be effective the first day of the month according to the regular prospective effective dates (as listed in the table on the cover sheet). Please specify below if you would like an accelerated effective date (which would start on the 1st of the month following our receipt of your completed Change Form).

- Change my medical plan
- Add or remove dependent(s)
- Add or cancel Providence Progressive Dental coverage
- Change my address after moving:  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE OF MOVE (REQUIRED)
- Report changes or corrections to a plan member's personal information (i.e. name, birthdate, tobacco status, etc.)

**Optional:** I would like an accelerated effective date.

- + If we receive your Change Form **March 1st–31st**, you will be given an **April 1st** effective date.
- + If we receive your Change Form **April 1st–30th**, you will be given a **May 1st** effective date.
- + If we receive your Change Form **May 1st–31st**, you will be given a **June 1st** effective date.
- + If we receive your Change Form **June 1st–30th**, you will be given a **July 1st** effective date.
- + If we receive your Change Form **July 1st–31st**, you will be given a **August 1st** effective date.
- + If we receive your Change Form **August 1st–15th**, you will be given a **September 1st** effective date.

Please note: If you have an active recurring payment arrangement with PHP and request a change with an accelerated effective date during the last week of the month, any changes to your premium rate may not update prior to the 1st of the month when recurring payments are processed. If your request results in a lower premium, your account will be credited on your next month's invoice. If your request results in a higher premium, PHP will bill you for the additional amount.

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\*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:

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](https://ProvidenceHealthPlan.com/sbc).

Applicable Counties	Network	Medical Plan (Check One)
Clackamas, Hood River, Multnomah, Washington, Yamhill (Newberg zip code 97132 only)	Connect*	<input type="checkbox"/> Connect 1500 Gold <input type="checkbox"/> Connect 4500 Silver <input type="checkbox"/> Connect 8550 Bronze
Benton, Clackamas, Clatsop, Crook, Deschutes, Douglas, Hood River, Jackson, Jefferson, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Washington, Yamhill	Choice*	<input type="checkbox"/> Oregon Standard Gold (Choice Network) <input type="checkbox"/> Oregon Standard Silver (Choice Network) <input type="checkbox"/> Oregon Standard Bronze (Choice Network) <input type="checkbox"/> 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	<input type="checkbox"/> Oregon Standard Gold (Signature Network) <input type="checkbox"/> Oregon Standard Silver (Signature Network) <input type="checkbox"/> Oregon Standard Bronze (Signature Network) <input type="checkbox"/> 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](https://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

**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](https://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](https://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. 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](http://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](http://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](mailto:phpindividualforms@providence.org)

**To fill out a Change Form online, visit [ProvidenceHealthPlan.com](http://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.