2021 Washington 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**.

Do not use this form if you purchased your plan through the **Washington Health Benefit Exchange.** You'll need to contact the Exchange at **WaHealthPlanFinder.org** or call 1-855-923-4633 to request changes to your plan.

To fill out a Change Form online, visit 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 or remove dependents
+ Cancel your medical plan
+ Change your address (moving to a new service area requires a change of medical plan - See the "Applicable Counties" list on page 2 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:
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.

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 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) ___/___/___

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 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 changes after having experienced a Qualifying Event:

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)

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):

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)

☐ 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.

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**.

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

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**.

Pediatric Dental Disclaimer: Our 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 Exchange, we must have reasonable assurance that you have obtained separate pediatric dental coverage through an Exchange-certified pediatric dental plan. This requirement applies whether you obtain coverage for children or adults. Exchange-certified pediatric dental plans can be found through the Washington Health Benefit Exchange at WaHealthPlanFinder.org.

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 all plans, dependent 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 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 contract. 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 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.)
7. I affirm that if I choose a medical plan without pediatric dental coverage, I will obtain pediatric dental coverage through a separate Exchange-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 State-registered Domestic Partner

SIGNATURE OF SPOUSE OR STATE-REGISTERED 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.