Providence Health Plan

PO Box 4649, Portland, OR 97208-4649

2025 Washington Individual & Family Open Enrollment Change Form

This form is for **Open Enrollment (Nov. 1, 2024 - Jan. 15, 2025)** changes only.

To fill out a change form online, visit **ProvidenceHealthPlan.com/INDChange2025**.

If you wish to enroll in a Providence Health Plan Individual & Family plan, submit your application at **ProvidenceHealthPlan.com/Shop** or contact our sales team at **503-574-5000** or **800-988-0088 (TTY: 711)**.

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 1–6 to request additional renewal changes.
- Submit only page 1 (the next page) to cancel your health plan coverage effective December 31, 2024.

Changes and effective dates:

Any change requests we receive between **Nov. 1, 2024 - Dec. 15, 2024** will take effect January 1, 2025. Any change requests we receive between **Dec. 16, 2024 - Jan. 15, 2025** will take effect February 1, 2025. Change forms we receive after **January 15, 2025** 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/Shop**. If you need help completing this form, contact your insurance producer or our membership accounting team at **503-574-5791** or **888-816-1300 (TTY: 711)** 8 a.m. to 5 p.m. (Pacific Time), Monday through Friday.

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 NAME _____ FIRST NAME _____ MI _____

SUBSCRIBER ID NUMBER _____ SOCIAL SECURITY NUMBER ___ – ___ – _____ DATE OF BIRTH (MM/DD/YYYY) ____/____/____

GENDER: ☐ Male ☐ Female ☐ Other

HOW DO YOU IDENTIFY? (These fields are optional. Your response will help us to better serve all communities.)

☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

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 six 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 December 31, 2024.**

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 2025. To get new coverage outside of the Open Enrollment Period (Nov. 1, 2024 - Jan. 15, 2025), you need to have a qualifying event for a Special Enrollment Period.

Sign, date, and submit only this page to cancel your coverage effective December 31, 2024.

Signature is considered valid only if it is handwritten ("wet") or e-signed.
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 (MM/DD/YYYY) ____/____/____

Option 2: Change Your 2025 Coverage

Open Enrollment is your opportunity to make changes to your current health plan coverage without requiring a qualifying event. The changes you request between Nov. 1 - Dec. 15, 2024 will become effective January 1, 2025. Change requests received between Dec. 16 - Jan. 15, 2025 will become effective February 1, 2025, conditioned on timely receipt of your premium payment.

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

Choose a New Medical Plan

Applicable Counties	Network	Medical Plan (Check One)
Benton, Clark, Franklin, Spokane, Thurston, Walla Walla	**Choice**	☐ Columbia 1500 Gold
		☐ Columbia 5000 Silver
		☐ Columbia 8900 Bronze

You'll need to choose a medical home and a primary care provider (PCP) after you enroll. Find an in-network provider at **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.

1 CHECK ONE:

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ___/___/___

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-___ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

2 CHECK ONE:

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ___/___/___

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-___ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

3 CHECK ONE:

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ___/___/___

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-___ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership by the secretary.
**Tobacco use is defined as an average of a least four times per week, except for religious or ceremonial purposes.
***These fields are optional. Your response will help us to better serve all communities.

Change Information for My Dependents Continued

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.

4 CHECK ONE:

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

5 CHECK ONE:

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

6 CHECK ONE:

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership by the secretary.
**Tobacco use is defined as an average of a least four times per week, except for religious or ceremonial purposes.
***These fields are optional. Your response will help us to better serve all communities.

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 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 Providence Health Plan and that Providence Health Plan 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 Providence Health Plan's privacy practices. I understand that I can get a copy of Providence Health Plan's Notice of Privacy Practices by going to **ProvidenceHealthPlan.com/NOPP** or by calling Customer Service at **503-574-7500** or **800-878-4445 (TTY: 711)** 8 a.m. to 5 p.m. (Pacific Time), Monday through Friday.

Signature

1. I understand that this is an Individual & Family 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 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 an Individual & Family health insurance plan that duplicates coverage available through Medicare.)
7. Providence Columbia plans DO NOT include pediatric dental coverage. I affirm that I will obtain pediatric dental coverage, for dependents under age 19, through a separate Marketplace-certified pediatric dental plan, and that I will notify Providence Health Plan if I do not obtain coverage. I understand that if I do not obtain pediatric dental coverage, Providence Health Plan will discontinue my or any of my enrolled dependents health benefits until reasonable assurance is obtained.

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.
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 (MM/DD/YYYY)

PRINT NAME

☐ Signed by Policyholder for Spouse or Domestic Partner

SIGNATURE OF SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)

Submission Options

Return completed form electronically:
Log in to your myProvidence account and send us a secure message with a copy of your completed change form attached.

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

Fax completed form to:
503-574-8131

Race/Ethnicity Questionnaire

Providence Health Plan

The following questions are optional. Your responses will help us to better serve all communities.

Which of the following describes your racial or ethnic identity? Please check all that apply.

Hispanic and Latino/a/x

- ☐ Hispanic or Latino/a/x Central American
- ☐ Hispanic or Latino/a/x Mexican
- ☐ Hispanic or Latino/a/x South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian or Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Other

- ☐ Other
- ☐ I don't know.
- ☐ I don't want to answer.

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

White

- ☐ Caucasian/White (no national affiliation)
- ☐ Eastern European/Slavic
- ☐ Western European
- ☐ Other White (African, Australian, New Zealand descent)

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Black or African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Afro-Latinx/Bi-racial/Other
- ☐ Other Black

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- ☐ **Yes** (please specify): _____
- ☐ **No:** I do not have just one primary racial or ethnic identity.
- ☐ **No:** I identify as Biracial or Multiracial.
- ☐ **N/A:** I only checked one category above.
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

What is your preferred spoken language?

- ☐ English
- ☐ Spanish
- ☐ Chinese - Other
- ☐ Mandarin
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ German
- ☐ French
- ☐ Tagalog
- ☐ Japanese
- ☐ Korean
- ☐ Arabic
- ☐ Decline/Unknown
- ☐ Other

What is your preferred written language?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Simplified Chinese
- ☐ Russian
- ☐ Other
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

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, sexual orientation, religion, gender identity, marital status 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, sexual orientation, religion, gender identity, marital status 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 need these services, you can call us at **503-574-7500** or **800-878-4445 (TTY: 711)**.

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

Providence Health Plan and Providence Health Assurance
Attn: Ronni Nichuals, Non-discrimination Coordinator
P.O. Box 4158
Portland, OR 97208-4158
Phone: 503-574-6236
Fax: 503-574-8757
Email: Ronni.Nichuals@providence.org

If need help filing a grievance, call us at **503-574-7500** or **800-878-4445 (TTY: 711)** for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, DC 20201
Phone: **800-368-1019** or **800-537-7697**

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at **888-877-4894** or visit **https://dfr.oregon.gov/Pages/index.aspx**.

Members of Washington Plans may file a complaint with the Washington Office of the Insurance Commissioner electronically through the Office of the Insurance Commissioner Complaint portal available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at 800-562-6900 or 800-537-7697 (TTY: 711) or visit **www.insurance.wa.gov**. Complaint forms are available at **http://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອ ດ້ານພາສາ ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).