PreferredOne®
ADMINISTRATIVE SERVICES

MEMBER CHANGE FORM

P.O. Box 59212 Minneapolis, MN 55459-0212
Customer Service (763) 847-4477 1-800-997-1750

Please use black or blue ink only. Do not highlight any areas on this form.

EMPLOYER TO COMPLETE

NAME OF EMPLOYER	GROUP NUMBER	EFFECTIVE DATE Month	Day	Year

CHANGE IN COVERAGE:

☐ Change subgroup from: _____ to: _____ Date: _____
☐ Change product from: _____ to: _____ Date: _____
☐ Change class from: _____ to: _____ Date: _____
☐ Change network from: _____ to: _____ Date: _____
☐ Member listed below has elected Minnesota Continuation (COBRA). Event date: _____
☐ Member listed below has elected Minnesota Continuation (COBRA). Paid date: _____

Reason for COBRA: ☐ Termination/reduction in work hours, layoff, strikes (18 months)
☐ Dependent child is ineligible (36 months)
☐ Death/divorce
☐ Other reason: _____

SIGNATURE OF EMPLOYER **X** _____	DATE SIGNED _____ / _____ / _____ month day year

EMPLOYEE TO COMPLETE

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER *(For Mandatory Federal/IRS Reporting[1])*

STREET ADDRESS / APT. NO.	CITY	STATE	ZIP CODE

EMPLOYEE'S TELEPHONE HOME ( ) BUSINESS ( )	EMAIL ADDRESS	☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Two or More Races

HISPANIC/LATINO: ☐ Yes ☐ No

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Hmong ☐ Cushite ☐ Vietnamese ☐ Chinese ☐ Russian ☐ Laotian ☐ Amharic ☐ Karen ☐ German ☐ Arabic ☐ Mon-Khmer Cambodian ☐ French ☐ Korean ☐ Tagalog ☐ Other: _____

DEMOGRAPHIC CHANGES:

☐ Change address/telephone to: _____
(STREET) (CITY) (STATE) (ZIP)

_____ _____
(HOME TELEPHONE) (BUSINESS TELEPHONE)

☐ Change name from: _____ to: _____

CHANGES AND ADDITIONS

☐ Open Enrollment
☐ MN Continuation (COBRA)
(begin date): _____
☐ Special Enrollment:
☐ Change in Coverage
New plan: _____
☐ Additions
☐ Add current Medical coverage to the dependent(s) listed below.

REASON FOR CHANGE: *(date of the event)* _____

☐ Employment Termination/Reduction in Work Hours ☐ Child Loses Dependent Status ☐ Death
☐ Employer Contributions Terminated for Non-COBRA Coverage ☐ Involuntary Loss of Other Coverage*
☐ Divorce/Legal Separation ☐ Birth ☐ Adoption/Placement for Adoption* ☐ Marriage
☐ COBRA Exhaustion ☐ Qualified Medical Child Support Order* ☐ Move outside of HMO Service Area
☐ Eligibility/Loss of Child Health Insurance Program (CHIP)/Medicaid*
☐ Loss of Minnesota Care*
☐ Other Reason: _____ *(*provide documentation)*

[1] Federal law requires that we ask for Social Security Numbers for mandatory reporting to the IRS each year. This field is requested but not required. Please note that the numbers are not used in determining eligibility for coverage.

FOR USE WITH SELF-INSURED DENTAL COVERAGE ONLY
Are any of the above listed dependent(s) age 19 or older, students? ☐ NO ☐ YES
If YES, please indicate the name, school attending and status

NAME _____ SCHOOL _____ ☐ Part-time ☐ Full-time

NAME _____ SCHOOL _____ ☐ Part-time ☐ Full-time

CANCELLATIONS

☐ Cancel all Medical (MD) and Dental (DT) coverage.
☐ Cancel all dependent Medical and Dental coverage only.
☐ Cancel all MD and DT coverage only on the dependent(s) listed below.
☐ Cancel all Medical coverage only.
☐ Cancel all Dental coverage only.
☐ Cancel all dependent Medical coverage only.
☐ Cancel all dependent Dental coverage only.
☐ Cancel Medical coverage only on the dependent(s) listed below.
☐ Cancel Dental coverage only on the dependent(s) listed below.

REASON FOR CANCELLATION:

☐ Employee terminated. Date: _____
☐ Employee reduction in work hours. Date: _____
☐ Employee layoff. Date: _____
☐ Strike. Date: _____
☐ Deceased. Date: _____
☐ Elected other coverage. Date: _____
☐ Dependent(s) now ineligible (e.g. loss of dependent status) or divorce/legal separation.
Last date of eligibility: _____
Reason: _____
☐ Reason: _____

FILL IN THE FOLLOWING INFORMATION FOR EACH ELIGIBLE DEPENDENT TO BE ENROLLED

DEPENDENT ONE

LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	M.I.	☐ MALE ☐ FEMALE
RELATIONSHIP	DATE OF BIRTH *(Month/Day/Year)*	SOCIAL SECURITY NUMBER *(For Mandatory Federal/IRS Reporting[1])*	

OPTIONAL *(Fill in all that apply)*
RACE/ETHNICITY: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Two or More Races
HISPANIC/LATINO: ☐ Yes ☐ No
PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Hmong ☐ Cushite ☐ Vietnamese ☐ Chinese ☐ Russian ☐ Laotian ☐ Amharic ☐ Karen ☐ German ☐ Arabic ☐ Mon-Khmer Cambodian ☐ French ☐ Korean ☐ Tagalog ☐ Other: _____

DEPENDENT TWO

LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	M.I.	☐ MALE ☐ FEMALE
RELATIONSHIP	DATE OF BIRTH *(Month/Day/Year)*	SOCIAL SECURITY NUMBER *(For Mandatory Federal/IRS Reporting[1])*	

OPTIONAL *(Fill in all that apply)*
RACE/ETHNICITY: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Two or More Races
HISPANIC/LATINO: ☐ Yes ☐ No
PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Hmong ☐ Cushite ☐ Vietnamese ☐ Chinese ☐ Russian ☐ Laotian ☐ Amharic ☐ Karen ☐ German ☐ Arabic ☐ Mon-Khmer Cambodian ☐ French ☐ Korean ☐ Tagalog ☐ Other: _____

DEPENDENT THREE

LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	M.I.	☐ MALE ☐ FEMALE
RELATIONSHIP	DATE OF BIRTH *(Month/Day/Year)*	SOCIAL SECURITY NUMBER *(For Mandatory Federal/IRS Reporting[1])*	

OPTIONAL *(Fill in all that apply)*
RACE/ETHNICITY: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Two or More Races
HISPANIC/LATINO: ☐ Yes ☐ No
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[1] Federal law requires that we ask for Social Security Numbers for mandatory reporting to the IRS each year. This field is requested but not required. Please note that the numbers are not used in determining eligibility for coverage.

Do all of the dependent(s) listed above reside at the same address as the employee? ☐ YES ☐ NO

If NO, list dependent(s) name and address: _____

If last name is different for dependents, please explain why: _____

Do you or any family members listed above have other health coverage in addition to this plan? ☐ NO ☐ YES

If YES, name(s): ☐ Single coverage ☐ Family coverage

Name of insurance company:

Are you enrolled in Medicare Part A, B or D? ☐ NO ☐ YES

If YES (attach a copy of Medicare card) effective date: Part A Part B Part D

Is your spouse and/or dependent enrolled in Medicare Part A, B or D? ☐ NO ☐ YES Name:

If YES (attach a copy of Medicare card) effective date: Part A Part B Part D

Reason for Medicare Coverage: ☐ Age 65 or older ☐ Under age 65 with a disability ☐ Under age 65 with end stage renal disease

Do you or any family members included on this change form have past or current medical coverage through a contract or plan through PreferredOne Community Health Plan (PCHP), PreferredOne Administrative Services (PAS), or PreferredOne Insurance Company (PIC)?

☐ NO ☐ YES If YES, please provide Employer Name (for group coverage):

Name(s) of all covered person(s):

By executing and submitting this change form, you give PIC/PCHP permission to view all claims history for you and your family members as a result of such coverage except for claims history that PAS obtained acting in its capacity as a preferred provider organization (PPO).

Are any age 26 or older dependents listed above incapacitated and incapable of self-sustaining employment because of physical disability, developmental disability, mental illness or mental health disorder and dependent on the employee for a majority of their financial support and maintenance? ☐ NO ☐ YES

If YES, list dependent(s) and date of onset of physical or mental disability and please provide supporting documentation as proof of incapacity.

_____

If you are declining major medical expense coverage for yourself or your dependents (including your spouse) because of other medical coverage, complete the box below.

I DECLINE COVERAGE FOR: ☐ Self ☐ Spouse ☐ Children ☐ Medical ☐ Dental

I am NOT applying for coverage because I have coverage through: ☐ Spouse's Group Plan ☐ Medicare ☐ COBRA/State Continuation ☐ MNCare ☐ Individual Policy ☐ Medical Assistance ☐ Other coverage reason: _____

Alternately, I am NOT applying for coverage because of: ☐ Cost ☐ Network ☐ Other reason: _____

I freely and voluntarily decline coverage as indicated above.

_____ _____

Date Employee Signature (If declining coverage)

NOTE: You and your dependents in the future may be eligible to enroll in this plan, provided that you apply for coverage within 31 days after other coverage ends, you lose eligibility for coverage or the employer stops contributing to your coverage. If you newly gain a spouse or eligible dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new spouse, along with your new dependent, provided that you apply for enrollment within 31 days after marriage and a covered employee may, at any time, enroll their newborn dependent child acquired as a result of birth, newly adopted dependent child or dependent child newly placed with the employee for adoption, provided that the employee is previously enrolled for coverage.

AUTHORIZATIONS for PreferredOne Administrative Services, Inc .(PAS) and Others to Receive, Disclose and Use ("Share") Your Health Information

I, for myself, and as applicable, any minor dependents, spouse or dependents age 18 or older covered by the medical plan option in which I am enrolling with this form, hereby authorize PAS and my employer to use and disclose my health information, including my protected health information as defined by HIPAA, claim information and explanation of benefits information ("Health Information"), to any health care provider and any subcontractor of a health care provider or of PAS that provides services for, or in connection with the medical plan option in which I am enrolling with this form; and I also authorize health care providers and the contractors and/or subcontractors of health care providers to use and disclose my health information to PAS with all such disclosures described herein between PAS, health care providers and contractors and/or subcontractors of health care providers for the purpose of managing my overall health status, my health conditions and diseases; for care coordination and quality improvement purposes; for disease management purposes; and for claim processing and payment purposes. This authorization also specifically allows PAS, health care providers and contractors and/or subcontractors to share my health information about care I have received or may receive in the future.

I, the applicant, for myself (and if applicable) my dependent applicants age 18 or older covered by the medical plan option in which I am enrolling with this form, hereby, authorize PAS, my employer health plan, and my providers to Share my Health Information specifically by and with, but not limited to, the following:

- PAS, for its plan administration, payment and/or operations
- Payers - Medicare, Medicaid and/or any other government health care programs, any other insurance company, health maintenance organization, payer network organization including an accountable care-type organization or network or other payer, and the contractors and subcontractors of such entities, for the payment and operations purposes of PreferredOne and each of them
- Providers – with respect to coverage and payment; so that individually and collectively they can better manage my overall health status and my specific health conditions and diseases, through care coordination, quality improvement, and disease management functions, and/or various payment arrangements; and in their role as accountable care-type organizations or networks or under other designated financial or contractual arrangements
- PAS's contractor and subcontractor service providers, including but not limited to PreferredOne's controlled group affiliates ("affiliates") – that assist PAS in carrying out its plan administration, payment and operations functions–including but not limited to coordinating benefits between payers, coordinating out-of-pocket payments for medical and pharmacy claims, pharmacy benefit management, disease and care management, utilization review and management, and other customer service and health claim-related activities

I understand and agree as follows:

- I will execute and submit all authorizations required by any third party (e.g., providers) for the release of my Health Information to PAS for plan administration, payment and/or operations purposes.
- My "Health Information" includes, but is not limited to, my "protected health information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and my "health records" and includes my past, present and future health records, which include but are not limited to, medical and pharmacy claims and related case notes, and information derived from them. These specifically include claims and case notes about HIV/AIDS, mental health and psychotherapy, substance use, and/or chemical dependency treatment.
- I am not allowed to modify the authorizations in this enrollment form; and if I do so, the enrollment form will not be valid.
- This authorization shall remain valid as long as I am enrolled in health care coverage provided through my employer health plan and administered through PAS, unless I revoke it as described below. A copy of this authorization is as valid as the original.
- This authorization is effective notwithstanding any other authorizations or revocations of authorizations that I enter into or have already entered into with my employer health plan, PAS, its affiliates and/or any providers. This authorization and any expiration or revocation thereof does not affect or change the routine sharing of my Health Information by my employer health plan, or between PAS, its affiliates and/or any providers, that is permitted or required under HIPAA or applicable state law.
- Information released pursuant to this authorization may be re-disclosed as permitted by law, in which case I understand that it may no longer be protected under federal privacy rules. I may revoke this authorization prospectively at any time, but only by submitting a valid written revocation to my employer health plan, or PAS's Customer Service Department; and can obtain revocation information from the Customer Service Department by calling (763) 847-4477 or toll free at 1-800-997-1750. Such revocation will be effective only after PAS receives it, and it will not affect PAS's or others' actions taken prior to receipt of the revocation.

ACKNOWLEDGEMENTS

To the best of my knowledge and belief the answers to the questions and the statements made on this completed enrollment form are true and complete, and I agree that any telephone conversations required to clarify information on this completed enrollment form are part of this enrollment form.

I further understand and agree as follows:

- If this form is submitted because of a special enrollment event, then this form amends my original enrollment form and will be incorporated into and made a part of the enrollment form and Summary Plan Description.
- Payment of a claim does not prevent PAS or my employer from denying future claims or taking any lawful action it determines appropriate, including rescission of coverage and seeking repayment of claims already paid.
- If PAS or my employer approves this enrollment form, it will issue a Summary Plan Description for me and, if applicable, the dependents listed in this form.
- In the event of a conflict between this enrollment form and the Summary Plan Description, the Summary Plan Description governs and PAS or my employer will administer coverage in accordance with the Summary Plan Description.
- I am not allowed to modify the acknowledgements in this enrollment form; and if I do so, the enrollment form will not be valid. PAS or my employer reserves and has the right to, in its sole discretion, request and/or rely on other documentation, to determine if any person listed in this enrollment form satisfies the requirements of this enrollment form.
- PAS or my employer will act in reliance upon the information I have provided herein.
- I must update and notify PAS or my employer of any change to the information that I have provided on this enrollment form that takes place between submission of the enrollment form and the effective date of coverage; and, failing to notify PAS or my employer of any change, providing false information or the omission of relevant information on this enrollment form which materially affects either the acceptance of risk or hazard assumed by PAS or my employer may result in denial of claims, rescission of coverage, or an increase in contributions, and may be considered insurance fraud.
- I must also notify PAS or my employer after coverage is effective of any changes to my information including my email address.

If my employer offers coverage for domestic partners, and I elect coverage for my domestic partner, I certify that my domestic partner and I: share the same permanent residence; are jointly responsible for basic living expenses; are not married to anyone and are each other's sole domestic partner with the intent to remain together indefinitely; are not related by blood closer than permitted under Minnesota marriage laws; are each mentally competent to consent to a contract; have completed or will complete a domestic partner affidavit form and have agreed or will agree to the conditions of such form.

If PAS or my employer issues coverage to me, I consent to receiving, through my secure member home page at www.preferredone.com, electronic delivery (in lieu of paper delivery) of the following information to the extent that PAS makes them available electronically: coverage documents, explanations of benefits, adverse determination notices, and summaries of benefits and coverage. I understand that PAS will notify me by email when such information is newly available, of the document's significance, and how to access the document at www.preferredone.com. I also consent to PAS notifying me exclusively via email at the email address I provided herein, of the availability of explanations of benefits. I understand that I may request a paper copy of these documents and/or to opt out of exclusively electronic delivery by contacting PAS' Customer Service Department at 1-800-997-1750 or (763) 847-4477 or accessing www.preferredone.com.

SIGNATURE

By signing below, I certify under penalty of perjury that: (i) I have completely read and fully understand the terms and conditions of this enrollment form; (ii) all the representations in this enrollment form are made by me and are true and complete; and (iii) I agree to the statements, authorizations, acknowledgements and terms of this enrollment form. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally responsible for all claims affected by such misrepresentation. I understand that I may be subject to penalties under law if I provide false or untrue information.

Applicant signature Date Print full name