Individual Medical Change Form

Send completed form to:
Individual Membership Accounting
P.O. Box 297, Minneapolis, MN 55440-0297
Toll Free 1-(888) 827-0181
See reverse page for fax and email options

Use this form for off-Marketplace changes only. If you enrolled through healthcare.gov, you must make changes through the healthcare.gov website.

This form can be used to make changes to your individual plan due to a Special Enrollment Period or voluntary termination. Please write all answers in ink. Answer all questions completely to avoid a delay in processing.

POLICYHOLDER'S NAME as it appears on your policy (Last name, First name, MI.)

____

MEMBER NUMBER:__________________ DATE OF BIRTH ____ /____ / _____ SOCIAL SECURITY NO. _______________

☐ **CHANGE ADDRESS** TO:

____

STREET ADDRESS APT/UNIT NO. PREFERRED TELEPHONE ( ) –

____

CITY COUNTY STATE ZIP ALTERNATE TELEPHONE ( ) –

____

CANCELLATION OF COVERAGE (specify)

- ☐ Cancel all coverage
- ☐ Cancel all dependent coverage only
- ☐ Cancel coverage only on the dependent(s) listed here:

Requested Cancellation date ____________________*

REASONS FOR CANCELLATION

- ☐ Divorce
- ☐ Death, date of death______________
  Name of deceased______________
- ☐ Dependent now ineligible
  Last date of eligibility ____ /____ / _______
- ☐ Other ___________________________

*For voluntary termination requests: Members may terminate their coverage at any time on the date specified by the member, <u>provided you have given us a 14-day notice</u>. If less than 14 days is given, your coverage will terminate 14 days from the date notice is received. You are responsible for paying any amounts owed for the time you are covered.

____

QUALIFYING LIFE EVENT:

☐ **ADDITIONS TO COVERAGE** Add coverage on the dependents listed below. Indicate reason for change:

- ☐ Birth Date of Birth ____/____/_____
- ☐ Marriage Date of Marriage ____ /____ / _______
- ☐ Adoption Date of Adoption placement ____/_____/____
- ☐ Other ____

Please submit supporting documentation to verify your life event. Failure to submit documentation may delay processing your requested change.

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DEPENDENT INFORMATION Complete the following information for each dependent you are adding

Last Name	First Name	MI	Relation-ship	Date of Birth (mm/dd/yyyy)	Gender (M/F)	Social Security Number	Tobacco Use* Y/N

***Tobacco Use:** Dependents 18 years of age or older. Health Care Reform defines use of tobacco as an average of four or more times per week within the past six months. This includes all tobacco products, but excludes religious and ceremonial uses. Tobacco use is based on when a tobacco product was last used. No documentation required for this change.

Do any of the dependent(s) listed above reside at a different address from the applicant?
Please list dependent(s) name and address:

____
____
____

Complete this section ONLY if you are changing plans due to a life event.

Plan Selection			
Nebraska - CoOportunity Premier Plan Options			
☐ Premier Catastrophic	☐ Premier Bronze	☐ Premier Silver	☐ Premier Gold
Nebraska – HSA Compatible Plan Options			
☐ Premier HSA Bronze	☐ Premier HSA Silver	☐ Premier HSA Gold	
Iowa - CoOportunity Premier Plan Options			
☐ Premier Catastrophic	☐ Premier Bronze	☐ Premier Silver	☐ Premier Gold
Iowa - CoOportunity CorePlus UI Health Alliance Plan Options			
☐ CorePlus UIHA Catastrophic	☐ CorePlus UIHA Bronze	☐ CorePlus UIHA Silver	☐ CorePlus UIHA Gold
Iowa - CoOportunity Preferred UI Health Alliance Plan Options			
☐ Preferred UIHA Catastrophic	☐ Preferred UIHA Bronze	☐ Preferred UIHA Silver	☐ Preferred UIHA Gold

Iowa - HSA Compatible Plan Options		
Premier HSA	**CorePlus HSA UI Health Alliance**	**Preferred HSA UI Health Alliance**
☐ Bronze ☐ Silver ☐ Gold	☐ Bronze ☐ Silver ☐ Gold	☐ Bronze ☐ Silver ☐ Gold

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OF COVERAGE. BY TYPING IN MY NAME AND DATE, I AM GIVING COOPORTUNITY HEALTH PERMISSION TO MAKE THE CHANGES OUTLINED IN THIS FORM.

____ _________________________________

SIGNATURE OF POLICYHOLDER (required) DATE SIGNED (required)

____

Relationship to policyholder if not self

Fax and email options to send completed forms:

Email: chpremiumbilling@healthpartners.com for your security, please do not put your member number, name or personal information on the subject line.
Fax Number: (952) 883 -5030 Please retain a copy of your fax confirmation for your records.

Please Note: Your request will be processed within 4 business days of receipt. You will receive confirmation of your requested change via mail, or on your next billing statement.

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