Medical Change Form

Send completed form to:
Individual Membership Accounting
P.O. Box 297, Minneapolis, MN 55425
Toll Free 1-(888) 880-9114
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** Requested Cancellation date _____*

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

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, provided you have given us a 14 day notice. 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 ____/____/_____
- ☐ Married 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.

_____

Continued on reverse

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

Last Name	First Name	MI	Relationship	Date of Birth (mm/dd/yyyy)	Gender (M/F)	Social Security Number

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 ☐ Premier Platinum		
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 ☐ Premier Platinum		
Iowa - CoOportunity Choice UI Health Alliance Plan Options		
☐ Choice UIHA Catastrophic ☐ Choice UIHA Bronze ☐ Choice UIHA Silver ☐ Choice UIHA Gold ☐ Choice UIHA Platinum		
Iowa - CoOportunity Preferred UI Health Alliance Plan Options		
☐ Preferred UIHA Catastrophic ☐ Preferred UIHA Bronze ☐ Preferred UIHA Silver ☐ Preferred UIHA Gold ☐ Preferred UIHA Platinum		
Iowa - HSA Compatible Plan Options		
Premier HSA	**Choice 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:

_____ _____

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: (952) 883 -5950 Important: please call toll free 1-(888)880-9114 to confirm receipt of fax.