PreferredOne®
COMMUNITY HEALTH PLAN

SMALL EMPLOYER MEMBER CHANGE FORM

P.O. Box 59052 Minneapolis, MN 55459-0052
(763) 847-4488 1-800-379-7727

SHADED AREAS TO BE COMPLETED BY EMPLOYER

NAME OF EMPLOYER	GROUP NUMBER	EFFECTIVE DATE OF CHANGE Month	Day	Year

CHANGE IN COVERAGE:

☐ Change subgroup from: ______ to: ______ Date ______ ☐ Change class from: ______ to: ______ Date ______
☐ Change plan from: ______ to: ______ Date ______ ☐ Change network from: ______ to: ______ Date ______
☐ Member listed below has elected Minnesota Continuation (COBRA). Event date ______
Reason: ☐ Termination/reduction in work hours, layoff, strike (18 months). ☐ Dependent child is ineligible (36 months). ☐ Death / divorce. ☐ Other. Reason ______

X ______
SIGNATURE OF EMPLOYER DATE OF SIGNATURE

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH Month	Day	Year	SOCIAL SECURITY NUMBER

STREET ADDRESS/APT. NO.

CITY STATE ZIP COUNTY

HOME PHONE	BUSINESS PHONE	E-MAIL
( )	( )	

DEMOGRAPHIC CHANGES:

☐ Change address/telephone to: ______
(STREET) (CITY) (STATE) (ZIP) (HOME TELEPHONE) (BUSINESS TELEPHONE)

☐ Change name from: ______ to: ______

CANCELLATIONS:

☐ Cancel all coverage.
☐ Cancel all dependent coverage only.
☐ Cancel 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.
☐ Dependent(s) now ineligible. Last date of eligibility ______
Reason ______
☐ Other. Reason ______

ADDITIONS: ☐ Add Medical coverage to the dependent(s) listed below. ☐ Add Dental coverage to the dependent(s) listed below.

REASON FOR ADDITION:

☐ Birth of child. Date ______ ☐ Marriage. Date ______ ☐ Open Enrollment. Date ______ ☐ Late Entrant. Date ______
☐ Special Enrollment (loss of coverage). Date ______
Reason: ☐ Termination/reduction in work hours. ☐ Employer contributions terminated. ☐ Divorce/legal separation. ☐ Death.
☐ Adoption / Placement for adoption. Date ______ *(provide legal documentation)*
☐ Qualified Medical Child Support Order. Date ______ *(provide legal documentation)*
☐ Other. Reason ______

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

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	MID. INIT.	RELATIONSHIP	SEX (M or F)	DATE OF BIRTH Month	Day	Year	HEIGHT	WEIGHT	SOCIAL SECURITY NUMBER

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 ______

Are any of the above listed dependent(s) age 19 or older, students? ☐ YES ☐ NO If yes, please indicate the name, school attending and if full-time

NAME ______ **SCHOOL** ______ **STATUS** ☐ Part-Time ☐ Full-Time

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

If yes, names: ______ ☐ Single Coverage ☐ Family Coverage

Name of insurance company ______

Are you covered by or eligible for Medicare Part A or B? ☐ NO ☐ YES - *(Attach a copy of Medicare card)* Effect. date: Part A ______ Part B ______

Are you covered by Medicare PartD? ☐ NO ☐ YES - Effect. date of Part D ______

Is your spouse and/or dependent covered by or eligible for Medicare Part A or B? ☐ NO ☐ YES - *(Attach a copy of Medicare card)* Effect. date: Part A ______ Part B ______

Is your spouse and/or dependent covered by Medicare PartD? ☐ NO ☐ YES - Effect. date of Part D ______

Does any family member included on this enrollment form currently have or have you had continuous health coverage or the last 12 months (18 months for late enrollment)?

☐ NO ☐ YES - please list carrier name, effective date and termination date ______

Have you ever been previously covered by PreferredOne Insurance Company (PIC)? ☐ YES ☐ NO If YES, what name(s) did you use? ______

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HEALTH INFORMATION: ***For confidentiality, the answers to these questions do not appear on the Employer copy.***

1. Have you or any family member eligible for coverage EVER been treated for, or diagnosed with, any of the following conditions? ☐ YES (please list details below) ☐ NO
   If **YES**, please check all that apply.

☐ alcohol use	☐ blood disorder	☐ drug use	☐ heart or circulatory disorder	☐ psychological or neurological disorder
☐ allergies	☐ cancer	☐ DWI/DUI	☐ immune system disorder	☐ reproduction system disorder
☐ arthritis	☐ counseling services	☐ eating disorder	☐ kidney or urinary tract disorder	☐ respiratory disorder
☐ asthma	☐ diabetes	☐ eye or ear disorder	☐ liver disorder	☐ seizure/epilepsy
☐ back disorder	☐ digestive or intestinal disorder	☐ headache/migraine	☐ muscle, bone or joint disorder	☐ stroke
				☐ thyroid disorder

☐ currently have a condition that may require medical, surgical or hospital care (explain)
☐ been hospitalized or had surgery for any condition or injury (explain)

IF YOU HAVE CHECKED ANY BOX ABOVE, PLEASE EXPLAIN WITH DETAILS BELOW:

PERSON'S NAME	DIAGNOSIS AND DETAILS ABOUT CONDITION, TREATMENT	DATE OF DIAGNOSIS	DATE OF RECOVERY	DAYS IN HOSPITAL

Is anyone currently pregnant? ☐ **Yes** ☐ **No If YES, please list the due date, describe any complications experienced or if multiple births are expected.**

2. MEDICATIONS: For each person eligible for coverage, complete the following (List ALL PAST and PRESENT medications used):

PERSON'S NAME	MEDICATION	REASON PRESCRIBED	DOSAGE (mg / gm)	# PER DAY	REFILLS PER YEAR	STILL PRESCRIBED?
						☐ yes ☐ no
						☐ yes ☐ no
						☐ yes ☐ no
						☐ yes ☐ no

Are any age 19 or older dependents listed above incapable of self-sutaining employment because of physical or mental handicap and dependent on the employee for a majority of their financial support? ☐ NO ☐ YES If YES, date of onset of physical or mental handicap: ____________ ***If yes, please provide supporting documentation.***

On behalf of myself and my enrolled dependents, I authorize any physician, medical practitioner, hospital, clinic, veterans' administration facility, or other medically related facility who has treated me and/or my dependents enrolled on this form, to release to PreferredOne Administrative Services, Inc. (acting for and on behalf of its self-funded plan clients or its affiliate's PreferredOne Community Health Plan or PreferredOne Insurance Company) information as to diagnosis, treatment, and prognosis with respect to any physical or mental conditions of me (or, if requested, my enrolled dependents) for insurance underwriting and plan administration purposes. This authorization excludes the release of information about HIV (AIDS virus) tests which were administered: 1) to a criminal offender or crime victim as a result of a crime that was reported to the police; 2) to a patient who received the services of emergency medical personnel at a hospital or medical facility; or 3) to emergency medical personnel who were tested as a result of performing emergency medical services. This authorization also excludes psychotherapy notes.

This authorization shall remain valid as long as I am continually covered by the medical and/or dental coverage in which I am enrolling with this form. I agree that a copy of this authorization shall be valid as the original. Information released pursuant to this authorization is released to an entity subject to the Health Insurance Portability and Accountability Act (HIPAA). This authorization may be revoked by submitting a written revocation to PreferredOne Customer Service. Such revocation will not effect actions taken prior to the revocation. Because this authorization is for underwriting, risk rating, and enrollment purposes, revocation of this authorization or failure to give this authorization may result in denial or termination of coverage.

I understand that I must update this form and resubmit it if anything changes that affects the information on this form between submission of the form and effective date of coverage. **I understand that providing false information or omission or relevant information on this form may result in denial of claims, cancellation of coverage, or an increase in premiums, and may be considered insurance fraud.** I understand that, subject to the terms and conditions of the certificate of coverage or plan under which I am enrolling for coverage, I may be subject to a pre-existing condition limitation.

SIGNATURE OF EMPLOYEE *(required)*	**X**	DATE SIGNED MONTH	DAY	YEAR