PreferredOne®
INSURANCE COMPANY

MEMBER CHANGE FORM

P.O. Box 59212 Minneapolis, MN 55459-0212
Customer Service (763) 847-4488 1-800-379-7727

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 paid for Minnesota Continuation (COBRA). Paid date: _____

Reason for COBRA: ☐ Termination/reduction in work hours, layoff, strike (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 month day year	SOCIAL SECURITY NUMBER *(For Mandatory Federal /IRS Reporting[1])*

STREET ADDRESS / APT. NO.

CITY STATE ZIP COUNTY

EMPLOYEE'S TELEPHONE	E-MAIL	☐ Male	☐ Single
HOME ( ) BUSINESS ( )		☐ Female	☐ Married

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

☐ Move outside of HMO Service Area ☐ Qualified Medical Child Support Order*

☐ Eligibility/Loss of Children Health Insurance Program (CHIP)/Medicaid*

☐ Loss of Minnesota Care* ☐ Other Reason _____

(*Provide documentation)

[1] Your Social Security number (SSN) is requested to identify you and your family and to report your coverage status to the federal government. The IRS requires PIC to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS or PIC, asking you to verify your SSN for tax purposes.

MEMBER NAME _____ SOC. SEC. # _____

MEMBER CHANGE FORM

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: _____

☐ Other reason: _____

FILL IN THE FOLLOWING INFORMATION FOR EACH ELIGIBLE DEPENDENT AFFECTED BY THE CHANGE OR CANCELLATION

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	M.I.	RELATIONSHIP	SEX M F	DATE OF BIRTH month day year	SOC. SECURITY NO. (For Mandatory Federal/IRS Reporting[1])

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 ☐ Medical ☐ 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).

[1] Your Social Security number (SSN) is requested to identify you and your family and to report your coverage status to the federal government. The IRS requires PIC to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS or PIC, asking you to verify your SSN for tax purposes.

MEMBER NAME _____ SOC. SEC. # _____

MEMBER CHANGE FORM

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 ☐ Cost ☐ 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 the date 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 the date of the marriage and a covered employee may, at any time, enroll his/her 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 and Others to Receive, Disclose and Use ("Share") Your Health Information

I, the applicant, for myself and any minor dependents or, if applicable, I the spouse or dependent age 18 or older, authorize PreferredOne, my health plan, my insurer, and my providers to Share my Health Information specifically by and with, but not limited to, the following:

- PreferredOne, for its plan administration, payment and/or operations
- Providers – in their role as accountable care-type organizations or networks or under other designated financial or contractual arrangements, 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
- 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
- PreferredOne's contractor and subcontractor service providers, including but not limited to PreferredOne Insurance Company and PreferredOne Community Health Plan (collectively "PreferredOne") and their affiliate PreferredOne Administrative Services, Inc. (all collectively "affiliates") – to assist PreferredOne 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 PreferredOne 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" as defined by Minnesota Statutes section 144.293; 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 form; and if I do so, the form will not be valid.
- This authorization shall remain valid as long as I am enrolled in health care coverage provided or administered by PreferredOne and its affiliates, unless I revoke it as described below. A copy of this authorization is 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 PreferredOne, 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 or between PreferredOne, 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 PreferredOne'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 PreferredOne receives it, and it will not affect PreferredOne'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 form are true and complete, and I agree that any telephone conversations required to clarify information on this completed form are part of this 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 form and certificate of coverage.
- Payment of a claim does not prevent PreferredOne from denying future claims or taking any lawful action it determines appropriate, including rescission of the certificate of coverage and seeking repayment of claims already paid.
- If PreferredOne approves this form, it will issue a certificate of coverage for me and, if applicable, the dependents listed in this form.
- In the event of a conflict between this form and the certificate of coverage, the certificate of coverage governs and PreferredOne will administer coverage in accordance with the certificate of coverage.
- I am not allowed to modify the acknowledgements in this form; and if I do so, the form will not be valid. PreferredOne 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 form satisfies the requirements of this form.
- PreferredOne will act in reliance upon the information I have provided herein.
- **I must update the information that I have provided on this form and resubmit it if any changes to the information take place between submission of the form and the effective date of coverage; and, failing to notify PreferredOne of any change, providing false information or the omission of relevant information on this form which materially affects either the acceptance of risk or hazard assumed by PreferredOne may result in denial of claims, rescission of coverage, or an increase in premiums, and may be considered insurance fraud.**

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.

❏ Yes ❏ No If PreferredOne issues coverage to me, I consent to receiving via email at the email address I provided herein, notice of the availability through the Internet and to electronic delivery of the following information: coverage documents, explanations of benefits, adverse determination notices, and summaries of benefits and coverage. I understand that PreferredOne will notify me when these documents are newly available, of the document's significance, and how to access the document at www.preferredone.com. I understand that, if I consent to email notice and electronic delivery, I may also request a paper copy of these documents from PreferredOne's Customer Service Department.

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 or by the applicant on my behalf, 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

_____

Spouse (if applying for coverage) Date Print full name

_____

Dependent signature (age 18 and older applying for coverage) Date Print full name

_____

Dependent signature (age 18 and older applying for coverage) Date Print full name

APPLIES ONLY TO PREFERREDONE INSURANCE COMPANY PLANS.

PreferredOne Insurance Company
6105 Golden Hills Drive
Golden Valley, MN 55416
763.847.4477 1.800.997.1750

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW.

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway Suite 101
White Bear Lake, MN 55110
Phone Number: 651.407.3149 Fax Number: 651.407.3150

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

PREFERREDONE INSURANCE COMPANY NONDISCRIMINATION NOTICE

PreferredOne Insurance Company ("PIC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PIC:

- Provides 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)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist
PreferredOne Insurance Company
PO Box 59212
Minneapolis, MN 55459-0212
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

LANGUAGE ASSISTANCE SERVICES

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.940.5049 (TTY: 763.847.4013).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.800.940.5049 (TTY: 763.847.4013)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.800.940.5049 (телетайп:763.847.4013).

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.800.940.5049 (TTY: 763.847.4013).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (መስማት ለተሳናቸው: 763.847.4013).

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၣ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1.800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1.800.940.5049 (TTY: 763.847.4013).។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (TTY: 763.847.4013).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013). 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).