



Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

## INDIVIDUAL PLAN CHANGE FORM

### Section 1 - Instructions

- ◆ Please read carefully.
- ◆ **Use ink to complete and sign this application. An application completed in pencil will be returned to you.**
- ◆ Make sure all sections of the application are answered completely.
- ◆ If you need assistance completing this application, please contact your agent or call Customer Service at 1 (800) 365-3155.

### Section 2 - Plan Selection

**NOTE:** If you are not already enrolled on one of the plans listed below or want to increase your benefits, you must complete an Oregon Application and Standard Health Statement. Please contact Customer Service or your agent for details.

**SELECT ONE MEDICAL PLAN PER APPLICATION.**

Refer to the Oregon Individual and Family Plans Brochure for plan details.

MEDICAL			
<b>BLUE SELECTIONS PREMIER</b> DEDUCTIBLES: Medical <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500  Uses Participating Providers on the <b>Preferred Provider Plan Network.</b>	<b>BLUE SELECTIONS PLUS</b> DEDUCTIBLES: Medical <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000  Uses Participating Providers on the <b>Preferred Provider Plan Network.</b>	<b>BLUE SELECTIONS BASIC</b> DEDUCTIBLES: Medical <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000  Uses Participating Providers on the <b>Preferred Provider Plan Network.</b>	<b>REGENCE HSA HEALTHPLAN</b> DEDUCTIBLES: Medical Single/Family <input type="checkbox"/> \$1,500/\$3,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$3,500/\$7,000  Uses Participating Providers on the <b>Participating Provider Network.</b>
DENTAL (optional)			
<input type="checkbox"/> Enroll in Individual Dentacare for all family members on my policy. Dental only coverage is not available.			
<input type="checkbox"/> Disenroll all family members on my policy from Individual Dentacare. I understand that I/we cannot reenroll for 12 months.			

(Please initial) **X** \_\_\_\_\_ "My employer is not paying the premium for this individual policy (including cafeteria plans)."

Individual benefit plans are not intended for sale as an employer sponsored health benefit plan for employees. For information on small employer health benefit plans, contact the Regence BlueCross BlueShield of Oregon Group Sales Department at 1 (800) 365-3155.

### Section 3 - Enrollment Information

Contract Identification Number

**LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED**

Last Name of Family Member	First Name, Middle Initial	Sex	Age	Birthdate	Social Security Number
Applicant					
<input type="checkbox"/> Spouse <input type="checkbox"/> Certified Domestic Partner <input type="checkbox"/> Non-Certified Domestic Partner *					
Child					
Child					
Child					
Child					

Explain the relationship to the applicant for any person(s) listed above whose last name is different from the applicant's. We may request a Certificate of Dependency form.

\* Non-Certified Domestic Partner must submit an Affidavit of Domestic Partnership.

<b>OREGON RESIDENCE ADDRESS</b>			
Name			
Address		PO Box (if applicable)	
City, State, ZIP Code			
Home Phone Number (    )	Work Phone Number (    )	County	OFFICE USE CO CODE

<b>BILLING ADDRESS (complete only if billing should be sent to an address other than listed above)</b>	
Name	
c/o	
Address	City, State, ZIP Code

OFFICE USE ONLY	Group Number & Pkg.	Identification Number	Contract Effective Date	Bill Period	Agent Number
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## Section 5 - Certification, Authorization and Signature

**Be sure to sign and date the application below. Spouse/Domestic Partner and/or dependent's (age 18 - 22) signature is required if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":**

### CERTIFICATION OF COMPLETION AND CORRECTNESS

**I affirm that the answers given in this application are complete and correct.** I am providing these answers as part of the application procedure required by Regence BlueCross BlueShield of Oregon (Regence BCBSO) to enroll in their insurance coverage. I understand that if this application contains any material misstatements or omissions, Regence BCBSO may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. I will promptly inform Regence BCBSO in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until the effective date determined by Regence BCBSO. Regence BCBSO may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

**I further affirm that I received a disclosure statement and outline of coverage from Regence BCBSO or its authorized agent describing the individual contract.**

### AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

On behalf of ourselves and the listed family member(s) below, we authorize, any physician, health care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to Regence BCBSO or its representatives our health information (including alcohol, chemical dependency, mental treatment, genetic testing or HIV treatment). We acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan, eligibility for benefits or payment of claims. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If you choose not to sign this authorization, we may be unable to enroll you in our health plan or to pay claims that were incurred while you had insurance coverage with us.

I may cancel this authorization at any time by sending a written request to Regence BCBSO. My cancellation of this authorization will not affect any action Regence BCBSO took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with Regence BCBSO or 24 months from the date below, whichever comes first.

Federal law requires Regence BCBSO to tell me that, if the party to whom Regence BCBSO discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, Part 2). Federal law prohibits redisclosure of this information without specified written authorization.

Signature of applicant, parent or legal guardian if applicant is under 18 years of age or legally incompetent *	Relationship	Date
<b>X</b>		
Signature of applicant's legal spouse or eligible domestic partner *		Date
<b>X</b>		
Signature of dependent(s) between 18 and 22 years of age *		Date
<b>X</b>		
Signature of dependent(s) between 18 and 22 years of age *		Date
<b>X</b>		

**\* If signature by a personal representative of the member/enrollee please complete the following:**

Personal Representative's Name (please print) \_\_\_\_\_

Relationship to Individual \_\_\_\_\_ (Attach legal documentation if other than parent of a minor child)

**THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES**

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)