



MEMBER CHANGE FORM
 P.O. Box 59212 Minneapolis, MN 55459-0212
 (763) 847-4477 1-800-997-1750

NAME OF EMPLOYER	GROUP NUMBER	EFFECTIVE DATE Month Day Year
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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 COBRA. Event date _____
 Reason: Termination/reduction in work hours, layoff, strike (18 months). Dependent child is ineligible (36 months). Death / divorce. Other. Reason _____

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH Month Day Year	SOCIAL SECURITY NUMBER
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STREET ADDRESS/APT. NO. _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

HOME PHONE () ()	BUSINESS PHONE () ()	E-MAIL
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DEMOGRAPHIC CHANGES:

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

Change name from: _____ to: _____

<p>CANCELLATIONS:</p> <p><input type="checkbox"/> Cancel all Medical (MD) and Dental (DT) coverage.</p> <p><input type="checkbox"/> Cancel all dependent Medical and Dental coverage only.</p> <p><input type="checkbox"/> Cancel all MD and DT coverage only on the dependent(s) listed below.</p> <p><input type="checkbox"/> Cancel all Medical coverage only.</p> <p><input type="checkbox"/> Cancel all Dental coverage only.</p> <p><input type="checkbox"/> Cancel all dependent Medical coverage only.</p> <p><input type="checkbox"/> Cancel all dependent Dental coverage only.</p> <p><input type="checkbox"/> Cancel Medical coverage only on the dependent(s) listed below.</p> <p><input type="checkbox"/> Cancel Dental coverage only on the dependent(s) listed below.</p>	<p>REASON FOR CANCELLATION:</p> <p><input type="checkbox"/> Employee terminated. Date _____</p> <p><input type="checkbox"/> Employee reduction in work hours. Date _____</p> <p><input type="checkbox"/> Employee layoff. Date _____</p> <p><input type="checkbox"/> Strike. Date _____</p> <p><input type="checkbox"/> Deceased. Date _____</p> <p><input type="checkbox"/> Elected other coverage.</p> <p><input type="checkbox"/> Dependent(s) now ineligible. Last date of eligibility _____ Reason _____</p> <p><input type="checkbox"/> Other. Reason _____</p>
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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 AFFECTED BY THE CHANGE.

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP	SEX (M or F)	DATE OF BIRTH Month Day Year	SOCIAL SECURITY NO.

Do you or any family members listed above have other coverage in addition to this plan? NO YES - Type: Medical Dental
 If yes, name(s) _____
 Name of insurance company _____
 Single coverage or Family coverage

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 Part D? NO YES - Effect. date of Part D _____

Is your spouse 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 covered by Medicare Part D? NO YES - Effect. date of Part D _____

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, full-time students? YES NO If yes, please indicate the name, school attending and if full-time

NAME	SCHOOL	STATUS
_____	_____	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
_____	_____	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time

Are any age 19 or older dependents listed above incapable of self-sustaining employment because of physical or mental handicap and dependent on the employee for a majority of their financial support? YES NO 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.

X SIGNATURE OF EMPLOYEE	Month Day Year DATE SIGNED	X SIGNATURE OF EMPLOYER (Required)	Month Day Year DATE SIGNED
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EMPLOYEE – COMPLETE ALL UNSHADED AREAS.