# POLICY CHANGE REQUEST FORM

P.O. Box 91110
Sioux Falls, SD 57109
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Fax: (605) 328-6812
sanfordhealthplan.com

**Name of Primary Contract Holder:** ___________________________ **Member ID #:** ______________________

**Current Address:** ________________________________________________________________________________

## Reason for Requested Change

**Date of Event**: ______/______/______ **Requested Effective Date for Change**: ______/______/______

**NOTE:** If more than 31 days have passed since the date of event, do not use this form. Instead, complete the elite1 *Application for Individual Health Insurance*. Changes in coverage or plan type may result in premiums being adjusted.

- ☐ Change in Plan Deductible/Coverage Type
- ☐ Dependent no longer eligible
- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce
- ☐ Death
- ☐ Moved outside of service area
- ☐ Medicare eligibility
- ☐ Remove tobacco-user surcharge
- ☐ Remove rider or rate-up
- ☐ Other (specify reason): ___________________________

## Policy/Contract Change Request

☐ **Change Plan*** ☐$1,000 ☐$1,500 ☐$2,000 ☐$2,500 ☐$5,000 ☐HSA-$1,550 ☐HSA-$2,550

*Lowering the deductible requires completion of an application and health questionnaire.

☐ **Change Coverage Type**
**From**: ☐ Self ☐ Individual + One ☐ Family
**To**: ☐ Self ☐ Individual + One ☐ Family

☐ **Addition of Dependent/Spouse***

| Last Name | First/M.I. | Address (if different) | Birth Date | Gender (M/F) | Social Security # | Relation | Tobacco Use? Y/N |
|---|---|---|---|---|---|---|---|
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*If dependent is over the age of 19, proof of full-time student status must be attached (i.e. letter of conditional acceptance, paid receipt, canceled check, letter from the institution or class schedule).

*1.* Has anyone listed above had previous health insurance coverage in the past 63 days? ☐Yes ☐No *If Yes, attach a copy of a Certificate of Creditable Coverage. If this is not attached, an assumption will be made that there was no prior creditable coverage and a pre-existing waiting period will apply. Separate pre-existing waiting periods apply according to each individual's prior creditable coverage.*

2. Will anyone listed above be insured on another health insurance policy besides this one? ☐Yes ☐No *If Yes, list*:

________________________________________________________________________________

Person Insured Effective Date Insurance Company Covered Individuals

☐ **Removal of Policyholder, Dependent or Spouse from the contract.** If you are removing the policyholder from the contract you must complete a new application to continue coverage for your remaining family members.

| Last Name | First/M.I. | Address (if different) | Birth Date | Gender (M/F) | Member ID # | Relation |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

☐ **Cancellation of Coverage** (specify reason for cancellation): ______________________________________
Coverage will be cancelled for the policyholder and all covered dependents if this box is checked. Cancellation will be processed the last day of the month in which this document is received.

☐ **Name Change:** From - ________________________________ to - ________________________________

☐ **Address Change:** New address: ____________________________________________________________

☐ **Death:** Deceased Member: ________________________________________________________________

☐ **Remove Rider or Rate-Up Amendment.** An amendment is not eligible for review/reconsideration until it has been in effect for a minimum of two years. Please list the medical condition(s) you would like reviewed: ______________________________

________________________________________________________________________________

☐ **Remove tobacco-user surcharge.** You must be covered under the Plan for twelve months before requesting to remove the tobacco user surcharge. A urinalysis test is required to verify tobacco abstinence.

## Notice of Contractual Waiting Periods

I certify I have been informed of and understand that the policy issued to me shall be subject to the following:

1. A 12-month waiting period for all medical conditions that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 6 months immediately preceding the effective date of coverage and all medical conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date of this policy. The waiting period shall also apply to medications used to treat medical condition(s).
2. Coverage will not be provided for a pregnancy existing on the effective date of coverage.
3. There will be credit given toward satisfying the pre-existing waiting periods contained in the policy for which you have applied if you or any family member has had creditable coverage within the last 63 days. The other coverage must have provided substantially similar coverage. All pre-existing waiting periods contained in the policy applied for shall commence from the effective date of the policy as assigned by Sanford Health Plan.

There will be no credit given under this policy for any deductible or out-of-pocket maximum amounts incurred by you or members of your family under any other Sanford Health Plan policies (except elite1 policies) or certificates of any other health insurance company.

## Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

If this coverage is intended to replace any health care coverage currently in force, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy or certificate if issued:

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your current policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical-health history. Failure to include all vital medical information on an application may provide a basis for Sanford Health Plan to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

## Agreement and Certification

As the current policy holder, I wish to request the following change(s) to my original policy as indicated on this form. I understand all other plan information currently in place on the elite1 health insurance policy, including but not limited to tobacco status, preexisting condition waiting periods, individuals covered under the elite1 health insurance policy, premium payment frequency and billing arrangements, health condition amendments and/or rate-up amendments will transfer to and remain in effect for the elite1 policy elected on this form. I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application.

I certify that after this change form was completed, I carefully and fully read it and that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Sanford Health Plan will rely on the completeness and truthfulness given in the statements made in this form, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Sanford Health Plan will be entitled to declare coverage provided under this policy void and to refuse allowance of benefits to any person hereunder.

## Signature

I have read and understand the Agreement and Certification language generated with this change form and acknowledged receipt of a fully completed copy of this form and Outline of Coverage for the health benefits, and how to access provider network information online at www.sanfordhealthplan.com or by contacting Member Services at 1-800-752-5863. I UNDERSTAND AND AGREE THAT THE HEALTH COVERAGE APPLIED FOR WILL NOT BE EFFECTIVE UNTIL SANFORD HEALTH PLAN, AS THE UNDERWRITER OF THE HEALTH COVERAGES, RESPECTIVELY, HAS REVIEWED AND APPROVED THIS CHANGE FORM AND NOTIFIED ME IN WRITING OF THE APPROVAL OF SUCH INSURER'S COVERAGE. SANFORD HEALTH PLAN UNDERWRITES COVERAGE UP TO THE EFFECTIVE DATE OF THE POLICY REGARDLESS OF WHEN THE CHANGE WAS APPROVED. SHOULD YOU HAVE ANY CHANGE IN HEALTH STATUS PRIOR TO THE EFFECTIVE DATE, YOU MUST NOTIFY SANFORD HEALTH PLAN. Should my change request not be approved, any applicable payment will be refunded in full. I understand that any health condition amendments or rate-up amendments previously signed and in effect on the current Sanford Health Plan policy will remain in effect under the Sanford Health Plan policy elected above. In the event I have selected HSA coverage on this application, I understand that enrolling in HSA coverage does not guarantee that I am or will be eligible to make contributions to a health savings account or that contributions can be made to a health savings account on my behalf.

Primary Applicant Signature　　Date Signed　　Spouse Signature　　Date Signed

Parent/Legal Guardian Signature (if applicant is under age 18)　　Printed Name　　Relation　　Date Signed

Agent Signature　　Agent Name　　Agent ID #:　　Date Signed

*For Office Use Only*

| Received | UW | Premium | Effective Date | Enrollment |
|---|---|---|---|---|
| | | | | |



*Disbursement: Health Plan, Agent, Member*