

Individual Policy Change Request Form



Subscriber Last Name	First Name	MI	Subscriber Number
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A. Check and complete the changes that apply and sign below

<input type="checkbox"/> Name Change	Change From	Change To	Reason For Change	
	If Married, Spouse's Name	Date of Marriage	Date of Divorce	
<input type="checkbox"/> Phone Number Change	<input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell		Change To	
<input type="checkbox"/> Email Address Change	Change To			
<input type="checkbox"/> Address Change <small>Disclaimer: If you move to a different county, rates or plan offerings may be affected.</small>	Change applies to <input type="radio"/> Residence Address <input type="radio"/> Mailing Address	Street/Route		Apartment Number
		City	State	ZIP Code

B. Change in Coverage (changes will be processed according to policy)

<input type="checkbox"/> Cancel Policy	Reason for Cancellation	Requested Cancellation Date
<input type="checkbox"/> Change Policy	Plan Name (selection, metal tier, deductible shown on page 2)	Effective Date of Change
<input type="checkbox"/> Cancel Policy	Qualifying Event <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Other: _____	Effective Date of Change
<input type="checkbox"/> Delete Dependent	Effective Date of Termination	Reason for Termination

C. Dependents

Please list family members to be added/deleted under this policy. Please attach additional form, if needed. Write name as it should appear on ID card. Dependents may not be eligible if other medical coverage is available to them through their employer.

Change <input type="radio"/> Add <input type="radio"/> Delete	Last Name	First Name	MI	Gender <input type="radio"/> M <input type="radio"/> F	Date of Birth	Social Security #	Tobacco Use? <input type="radio"/> Y <input type="radio"/> N
Change <input type="radio"/> Add <input type="radio"/> Delete	Last Name	First Name	MI	Gender <input type="radio"/> M <input type="radio"/> F	Date of Birth	Social Security #	Tobacco Use? <input type="radio"/> Y <input type="radio"/> N
Change <input type="radio"/> Add <input type="radio"/> Delete	Last Name	First Name	MI	Gender <input type="radio"/> M <input type="radio"/> F	Date of Birth	Social Security #	Tobacco Use? <input type="radio"/> Y <input type="radio"/> N
Change <input type="radio"/> Add <input type="radio"/> Delete	Last Name	First Name	MI	Gender <input type="radio"/> M <input type="radio"/> F	Date of Birth	Social Security #	Tobacco Use? <input type="radio"/> Y <input type="radio"/> N

D. Type of Coverage and Benefit Plans

Plan ID	Plan Name	Deductible	Coinsurance	Out-of-Pocket	Convenient Care Clinic Copay	Office Visit Copay****	Prescription Drugs [Preventive, Tier 1, Tier 2, Tier 3, Specialty]	
HMO COPAY PLANS								
<input type="checkbox"/>	86584WI0010011	Bronze 7500*****	\$7,500	50%	\$10,000	\$50	\$50 PCP \$100 Specialist	\$0 / \$25 / Ded then \$50 / Ded then \$100 / Ded then \$500
<input type="checkbox"/>	86584WI0010001	Silver 6600	\$6,600	30%	\$8,600	\$10	\$40 PCP \$80 Specialist	\$0 / \$20 / \$40 / Ded then \$80 / Ded then \$350
<input type="checkbox"/>	86584WI0010012	Silver 6000 *	\$6,000	40%	\$8,900	\$40	\$40 PCP \$80 Specialist	\$0 / \$20 / \$40 / Ded then \$80 / Ded then \$350
<input type="checkbox"/>	86584WI0010007	Gold 2700	\$2,700	30%	\$7,000	\$10	\$30 PCP \$60 Specialist	\$0 / \$15 / \$30 / \$60 / \$250
<input type="checkbox"/>	86584WI0010015	Gold 2000 *	\$2,000	25%	\$8,200	\$30	\$30 PCP \$60 Specialist	\$0 / \$15 / \$30 / \$60 / \$250
<input type="checkbox"/>	86584WI0010016	HMO Bronze 0 Medical Deductible *****	\$0	50%	\$10,600	\$10	\$35 PCP \$200 Specialist	\$0 / \$35 / \$125 D/C all others
<input type="checkbox"/>	86584WI0010008	Catastrophic 10600 With 3 Free PCP Visits *****	\$10,600	0%	\$10,600	D/C	D/C	\$0 preventive D/C all others
HMO - DEDUCTIBLE PLANS								
<input type="checkbox"/>	86584WI0010009	Bronze 10,000*****	\$10,000	0%	\$10,000	D/C	D/C	\$0 preventive, D/C all others
<input type="checkbox"/>	86584WI0010013	HDHP Silver 5900*****	\$5,900	0%	\$5,900	D/C	D/C	\$0 preventive, D/C all others
POS - COPAY PLANS								
<input type="checkbox"/>	86584WI0020005	Bronze 7500 *****	\$7,500	50%	\$10,000	\$50	\$50 PCP \$100 Specialist	\$0 / \$25 / Ded then \$50 / Ded then \$100/ Ded then \$500
<input type="checkbox"/>	86584WI0020001	Silver 6000 *	\$6,000	40%	\$8,900	\$40	\$40 PCP \$80 Specialist	\$0 / \$20 / \$40 / Ded then \$80 / Ded then \$350
POS - DEDUCTIBLE PLANS								
<input type="checkbox"/>	86584WI0020003	Bronze 8500*****	\$8,500	30%	\$9,500	D/C	D/C	\$0 preventive D/C all others

D/C = Deductible and Coinsurance Ded = Deductible PCP = Primary Care Practitioner HMO = Health Maintenance Plan POS = Point-of-Service Plan

* Standardized plan option

** Eligibility limited to persons under age 30, or those with a hardship exemption from the Federally Facilitated Marketplace.

*** Separate RX Deductible \$1500

**** The same benefit applies to telemedicine.

***** HSA Qualified Plan

E. Certification

CERTIFICATION: I represent and certify all of the following: no answer or information written by myself in this application was provided by the agent or anyone else (except for information provided by other family members); such representations are true, accurate, and complete to the best of my knowledge.

Subscriber Signature	Date
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You may email this form to the attention of Aspirus Individual Product Department at IndividualSales@aspirushealthplan.com, or mail to Attn: Individual Product Department, PO Box 1890, Southampton, PA 18966. Please call 866.631.4611 Sales Option #2 with any questions.

Nondiscrimination & Language Access Policy



Discrimination is Against the Law. Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.10(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If you believe that Aspirus Health Plan, Inc. 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:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
Phone: 1-866-631-5404 (TTY: 711) Fax: 763-847-4010
Email: customerservice@aspirushealthplan.com

You can file a *grievance* in person or by mail, fax, or email. If you need help filing a *grievance*, the Nondiscrimination Grievance Coordinator 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>. This notice is available at Aspirus Health Plan, Inc.'s website: https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim_Lang-Assist-Notice.pdf.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-631-5404 (TTY: 711).

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف 1-866-631-5404 (رقم هاتف الصم والبك : 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-631-5404 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-631-5404 (TTY: 711).

Hindi: यान द य द आप िहंदी बोलते ह तो आपके िलए मु त म भाषा सहायता सेवाएं उपल थ ह । 1-866-631-5404 (TTY: 711) पर कॉल कर ।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-631-5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-631-5404 (TTY: 711) 번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-631-5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-631-5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-631-5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-866-631-5404 (TTY: 711).

Traditional Chinese: 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 1-866-631-5404 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-631-5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetscht, kannst du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprouch. Ruf selli Nummer uff: Call 1-866-631-5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 1-866-631-5404 (TTY: 711).