Regence

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

Regence BlueCross BlueShield of Oregon
Clark County Washington
100 SW Market Street
Portland, OR 97207-1271
Mail form to: PO Box 1106, MS-LB1
Lewiston, ID 83501

Plan Change Request

Policyholder Name (please print) _____

NOTE: All family members currently active on this policy will be included in the policy change.

TYPE OF REQUEST - Most changes are effective the first of the month following receipt of this form

Change current individual plan to lesser benefits. Select plan and complete signature area below. Your policy must be paid current in order for a plan change to be made. If your policy is terminated due to non-payment of premium, you will need to re-apply by sumitting a new application.

NOTE: If you want to increase your benefits, discard this form and complete an application and Standard Health Questionnaire.

PLAN SELECTION - Detailed benefit information can be found online at www.regence.com

MEDICAL PLANS (select ONE medical plan)

Enrollment in a catastrophic health plan may not provide portability if you later decide to enroll in another individual health plan. "Portability" means that you will receive credit for a plan's preexisting condition waiting period based on prior coverage. By enrolling in a catastrophic plan, you may lose portability rights and have to satisfy the nine-month preexisting waiting period, should you later change to another individual health plan. All deductible options listed below are catastrophic unless otherwise indicated. **The preexisting waiting period may not apply to any members under the age of 19.**

Evolve Core

Deductibles are per member (3 individual deductibles satisfy the family deductible)

☐ $2,500 - Catastrophic ☐ $5,000 - Catastrophic ☐ $7,500 - Catastrophic ☐ $10,000 - Catastrophic

Evolve Plus

Deductibles are per member (3 individual deductibles satisfy the family deductible)

☐ $1,000 - Comprehensive ☐ $2,500 - Catastrophic ☐ $5,000 - Catastrophic ☐ $7,500 - Catastrophic

Evolve HSA

Self-Only Deductibles	Family Deductibles
☐ $2,000 with 50% coinsurance - Catastrophic	☐ $4,000 with 50% coinsurance - Catastrophic
☐ $2,000 with 80% coinsurance - Catastrophic	☐ $4,000 with 80% coinsurance - Catastrophic
☐ $3,500 with 50% coinsurance - Catastrophic	☐ $7,000 with 50% coinsurance - Catastrophic
☐ $3,500 with 80% coinsurance - Catastrophic	☐ $7,000 with 80% coinsurance - Catastrophic

Evolve HSA 100

☐ $5,000 self-only deductible - Catastrophic ☐ $10,000 family deductible - Catastrophic

DENTAL OPTIONS (check one)

☐ **No Dental**
☐ **Dental Rewards Option** - 100/80/50; $750 annual maximum benefit that may increase over time to $1,500
☐ **Dental Option 2** - 100% of first $200 and 50% of next $1,100 ($750 annual maximum benefit)

Conditions of this Change Request

By completing and signing this form, I agree to and understand the following:

- If my rates are paid current, coverage for myself and dependents currently covered on my plan will be changed to the plan I am selecting on this form.
- A new policy will be issued and all terms and conditions of the new policy will be effective the first of the month following the date this change request is received by us, unless otherwise noted.

Policyholder's Signature ▶ _____ Date (mm/dd/yyyy) _____

Member Identification Number ☐☐☐☐☐☐☐☐☐ Phone Number (xxx) xxx-xxxx

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