Regence

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

Regence BlueCross BlueShield of Oregon
100 SW Market Street
Portland, Oregon 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.

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

MEDICAL PLANS (select ONE medical plan)

Evolve Core

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

☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

Evolve Plus

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

☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $7,500

Evolve HSA

Self-Only Deductibles	Family Deductibles
☐ $1,500 with 50% coinsurance	☐ $3,000 with 50% coinsurance
☐ $1,500 with 80% coinsurance	☐ $3,000 with 80% coinsurance
☐ $3,500 with 50% coinsurance	☐ $7,000 with 50% coinsurance
☐ $3,500 with 80% coinsurance	☐ $7,000 with 80% coinsurance

Evolve HSA 100

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

DENTAL OPTIONS (check one)

☐ **No Dental**
☐ **Dental Option 1** - 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 _____