Policy Change Request

for Sanford *Simplicity* Individual & Sanford TRUE Individual Plans

PO Box 91110
Sioux Falls, SD 57109
(605) 328-6800 | 1-800-752-5863
Fax: (605) 328-7001
sanfordhealthplan.com

SANFORD HEALTH PLAN

NOTE: If you purchased your plan at healthcare.gov, you must submit changes directly through your Marketplace account.

Primary contract holder name: _____ **Member ID #:** _____

Phone number: _____ **Email:** _____ **Date of birth:** _____

Current address: _____
Street City State Zip Code

Help understanding this document is free.
If you would like this document in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at: (800) 752-5863 (toll-free) | TTY: 711.

Help in a language other than English is also free.
Please call (800) 752-5863 (toll-free) | TTY: 711 to connect with us using free translation services.

Requested change or termination

☐ **Special Enrollment Period**

☐ **Open Enrollment Period**

☐ **Cancellation of coverage** *(specify reason for cancellation)*: _____
Coverage will be cancelled for the policyholder and all covered dependents if this box is checked. Cancellation requests must be received by the 15th of the month in order to be effective the last day of the month in which this document is received unless a later date is specified. Midmonth terminations are not accepted.

Reason for requested change or termination

☐ Loss of eligibility for other group/individual coverage
☐ Loss of eligibility for Medicaid/CHIP
☐ Exhaustion of COBRA
☐ Marriage - If applicable, list name change: _____
☐ Birth/Adoption/Placement of Foster Child
☐ Divorce - If applicable, list name change: _____
☐ Marketplace enrollees newly ineligible for Subsidies/CSR
☐ Death
☐ Move to new service area
☐ Medicare or Medicaid eligibility
☐ Dependent no longer eligible
☐ Other _____

Date of Event: _____/_____/_____ **Requested Effective Date for Change:** _____/_____/_____
This request will be reviewed based upon eligibility guidelines. You will be notified if an alternative effective date is required.

IMPORTANT: This request must be signed within 60 days of the event and Sanford Health Plan must receive this within 60 days of the event to process your request. If this requirement is not met, changes cannot be made until the next annual open enrollment period. Contact your local insurance agent or call (800) 251-5316 or (605) 328-7000 for information on the required documentation to process this request.

Deductible/eligibility change

Plan changes are only allowed during the annual open enrollment period or special enrollment period.

☐ **Deductible plan change**

Sanford Simplicity Individual: ☐ *$1,750* ☐ *$2,800* ☐ *$3,500* ☐ *$4,750* ☐ *$5,250 HSA* ☐ *$6,000* ☐ *$7,000* ☐ *$7,100 HSA* ☐ *$9,450**
Standardized Plans: ☐ *$1,500* ☐ *$5,900* ☐ *$7,500*
Enhanced — Diabetes & Asthma/COPD Care Plans: ☐ *$1,250* ☐ *$3,700 HSA*

Sanford TRUE Individual: ☐ *$1,750* ☐ *$2,800* ☐ *$3,500* ☐ *$4,750* ☐ *$5,250 HSA* ☐ *$6,000* ☐ *$7,000* ☐ *$7,100 HSA* ☐ *$9,450**
Standardized Plans: ☐ *$1,500* ☐ *$5,900* ☐ *$7,500*
Enhanced - Diabetes & Asthma/COPD Care Plans: ☐ *$1,250* ☐ *$3,700 HSA*

*Only available for those under age 30, or those with hardship exemption.
NOTE: If you are electing a TRUE product, you must reside in a TRUE approved county. TRUE approved counties include the following: For South Dakota — Brown, Lincoln, and Minnehaha; For North Dakota — Burleigh, Oliver, Morton, Cass, and Traill. Please check with your Agent or Sanford Health Plan for more details.

☐ **Add/remove dependent/spouse.** Fill out chart below:

- **Addition of Dependent/Spouse.** For South Dakota members only: If dependent is 26 or older, 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).
- **Removal of dependent or spouse from the contract.** If the policyholder is being removed from the contract, you must complete a new application to continue coverage for you or your remaining family members.

	Last Name	First/M.I.	Address (if different)	Birth Date	Gender M/F	Social Security #	Relation
☐ Add ☐ Remove							
☐ Add ☐ Remove							
☐ Add ☐ Remove							

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*

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. 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.
2. 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. 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 Simplicity health insurance policy, individuals covered under the Simplicity health insurance policy, premium payment frequency and billing arrangements will transfer to and remain in effect for the Simplicity 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. An act, practice, or omission that constitutes fraud or intentional misrepresentations of material facts, made by an applicant for health insurance coverage may be used to void this form or policy and deny claims to any person covered under this Policy.

Sanford Health Plan complies with applicable federal civil rights laws, and does not discriminate on the basis of race, color, national origin, age, disability, gender, gender identity, sex, or sexual orientation.

Notice of Non-Discrimination

Sanford Health Plan does not discriminate against any future, current, or past Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; spiritual beliefs; medical condition, including a current or past history of mental health and substance use disorders; sources of payment for care; or age, in its coverage, treatment, or benefit decisions.

Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, or other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Sanford Health Plan at (800) 752-5863 | TTY: 711.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator at 300 Cherapa Place #201, Sioux Falls, SD 57103, call (800) 325-9402 | TTY: 711, fax (605) 328-6812, or e-mail compliancehotline@sanfordhealth.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the US 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: US Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, TTY/TDD (800) 537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/

Michelle's Law

Federal law requires that we provide the following notice regarding Michelle's Law [Public Law 110-381]. Please note that changes in federal law may eliminate certain elements of Michelle's Law, and the Plan intends to provide continuing coverage of Eligible Dependents up to age twenty-six (26), irrespective of their student status, for Plan Years beginning on or after September 23, 2010.

A Dependent Child enrolled in, and attending, an accredited college, university, trade, or secondary school at least five (5) months each year will remain covered if the Dependent takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

1. Be medically necessary;
2. Commence while the child is suffering from a serious illness or injury; and
3. Cause the child to lose coverage under the plan.

Students are only eligible as long as they were covered by their parent's health insurance policy prior to diagnosis. Coverage will continue until the earlier of one year from the first day of the leave of absence or the date on which coverage would otherwise terminate because the child no longer meets the requirements to be an Eligible Dependent (e.g., reaching the plan's limiting age).

You must provide a signed, written document from the Dependent Child's treating Practitioner/Provider stating all of the following: 1) the Dependent Child is suffering from a serious illness or injury necessitating a medical leave of absence; 2) the treating Practitioner/Provider certifies such leave of absence is Medically Necessary; and 3) the dates when the Dependent will be either on a medically necessary leave of absence from school or will be changing to part-time status due to a serious illness or injury.

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 Summary of Benefits and Coverage for the health benefits, and how to access provider network information online at www.sanfordhealthplan.com or by contacting Member Services at (800) 752-5863. I UNDERSTAND AND AGREE THAT THE HEALTH COVERAGE APPLIED FOR WILL NOT BE EFFECTIVE UNTIL SANFORD HEALTH PLAN 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 my change request not be approved, any applicable payment will be refunded in full.

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 _____

NPN # _____

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