HealthPartners®

CHANGE FORM

8170 33rd AVENUE SOUTH, PO BOX 297, MINNEAPOLIS, MN 55440-0297

NAME OF EMPLOYER	GROUP NUMBER	EFFECTIVE DATE OF CHANGE:
SUBGROUP CHANGE FROM _____ TO _____	EMPLOYEE STATUS ❑ Active ❑ Retired ❑ COBRA	EMPLOYEE DISABILITY* ❑ Yes ❑ No

EMPLOYEE: COMPLETE ALL UNSHADED AREAS If you are requesting to change your clinic, you DO NOT need to complete this form. Simply call Member Services at 952-883-5000 or 800-883-2177.

EMPLOYEE'S LAST NAME (LEGAL NAME)			DATE OF BIRTH
FIRST NAME		M.I.	SOCIAL SECURITY NO.
❑ **CHANGE ADDRESS** TO: STREET ADDRESS		APT. NO.	WORK TELEPHONE
CITY	STATE	ZIP	HOME TELEPHONE
❑ **CHANGE NAME** FROM:			TO:

CHECK TYPE OF PLAN(S) AFFECTED BY CHANGE: ❑ MEDICAL ❑ DENTAL ❑ MEDICAL AND DENTAL

❑ **CANCELLATION OF COVERAGE**

CANCELLATIONS

- ❑ Cancel all coverage
- ❑ Cancel all dependent coverage only
- ❑ Cancel coverage only on the dependent(s) listed below

REASONS FOR CANCELLATION

- ❑ Employee terminated
- ❑ Employee now ineligible
- ❑ Dependent now ineligible

Last date of eligibility _____

- ❑ Moved outside of area
- ❑ Divorce
- ❑ Other
- ❑ Dissatisfied
- ❑ Death

❑ **COBRA CONTINUATION** Qualifying event: Event Date

❑ **MEDICAL PLAN CHANGE** From:
Plan _____
to Plan _____

❑ DENTAL PLAN CHANGE From:
Plan _____
to Plan _____

If you have dependents, see below. This change may only be made upon renewal. Once change is made, plan election will remain in force until next renewal date.

❑ **ADDITIONS TO COVERAGE** Add coverage on the dependents listed below. Indicate reason for change:

- ❑ Birth
- ❑ Married on _____
- ❑ Life event _____ Date _____

DEPENDENT INFORMATION Complete the following information for each dependent affected by the change. Please be sure to list clinic choice for each dependent.

LAST NAME (IF DIFFERENT)	FIRST NAME	MI	DATE OF BIRTH	SEX (M/F)	SOCIAL SECURITY NUMBER	RELATIONSHIP TO EMPLOYEE	CLINIC NUMBER*	DISABILITY** (Y/N)

**Primary clinic plans only **Federal Medicare legislation now requires this information. If you have questions, contact Member Services.*

Do any of the dependent(s) listed above reside at a different address from the applicant?
❑ NO ❑ YES If YES, list dependent(s) name and address: _____

At the time of your effective date with HealthPartners, will you, your spouse, and/or dependent(s) be insured by any other health insurance company?
❑ NO ❑ YES If YES, please complete the Coordination of Benefits Form. Check which type: ❑ Group ❑ Individual

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OF COVERAGE:

SIGNATURE OF EMPLOYEE (required) _____ DATE SIGNED _____ SIGNATURE OF EMPLOYER (optional) _____ DATE SIGNED _____

Statement of Nondiscrimination for Health Plan Members

Our Responsibilities:
We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity.

- We help people with disabilities to communicate with us. This help is free. It includes:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
  - Qualified interpreters
  - Information written in other languages

For Language or Communication Help:
Call 1-800-883-2177 if you need language or other communication help. (TTY: 711)

If you have questions about our non-discrimination policy:
Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@healthpartners.com.

To File a Grievance:
If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, integrityandcompliance@healthpartners.com or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave S., Bloomington, MN 55425.

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
Room 509F, HHH Building
200 Independence Avenue SW
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Español *(Spanish)*	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-883-2177. (TTY: 711)
Hmoob *(Hmong)*	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-883-2177. (TTY: 711)
Tiếng Việt *(Vietnamese)*	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-883-2177. (TTY: 711)
繁體中文 *(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 1-800-883-2177. (TTY: 711)
Русский *(Russian)*	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)
Af Soomaali *(Somali)*	OGAYSIIS: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)

Additional languages listed on page 2

21849 (9/2016)

ພາສາລາວ *(Laotian)*	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-883-2177. (TTY: 711)
Deutsch *(German)*	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)
العربية *(Arabic)*	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177(رقم هاتف الصم والبكم: 711
Français *(French)*	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)
한국어 *(Korean)*	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)
Tagalog *(Tagalog)*	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)
Oroomiffa *(Cushite [Oromo])*	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)
አማርኛም *(Amharic)*	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደም ሚከተለው ቁጥር ይደውሉም-800-883-2177. (መስማት ለተሳናቸው: 711)
unD *(Karen)*	ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ်၊ ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-800-883-2177. (TTY: 711)
ខ្មែរ *(Mon-Khmer, Cambodian)*	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-883-2177. (TTY: 711)
Deitsch *(Pennsylvanian Dutch)*	Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-883-2177. (TTY: 711)
Polski *(Polish)*	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)
हिंदी *(Hindi)*	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता `वाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)
Shqip *(Albanian)*	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)
Srpsko-hrvatski *(Serbo-Croatian)*	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-883-2177. (TTY: 711)
ગુજરાતી *(Gujarati)*	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-883-2177. (TTY: 711)
اُردُو *(Urdu)*	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-883-2177 (TTY: 711).
Italiano *(Italian)*	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)
ภาษาไทย *(Thai)*	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)
ελληνικά *(Greek)*	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)
Diné Bizaad *(Navajo)*	Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-883-2177. (TTY: 711)