

**ELECT:
INDIVIDUAL POLICY
CHANGE FORM**



This form may only be used to make the changes listed below. For any other changes, please complete a new Elect Policy Application, instead of this form. If you have any questions, please contact the PacificSource Individual Sales Department by phone at (541) 684-5585 or (866) 695-8684, or by e-mail at individual@pacificsource.com.

This change is to (check one):

- Add a newborn child within 31 days of birth
Date of birth: _____
- Add a newly adopted child within 31 days of placement *(attach copy of adoption papers)*
Date of placement: _____
- Become the main insured on an existing policy
- Transfer from another existing policy (same plan design and deductible level)
- Transfer to a separate policy (same plan design and deductible level)

If the change is due to death, divorce or dissolution of domestic partnership, provide the date:

- Death - Date: _____
- Divorce - Date: _____
- Dissolution of domestic partnership - Date: _____

If the change is to add a newly acquired spouse, domestic partner, or dependent children (other than a newborn child or newly adopted child) due to marriage or registration of a domestic partnership, the newly acquired dependents are subject to medical underwriting. Please complete a new Elect Policy Application, listing your newly acquired family members, instead of this form.

Current policyholder's social security or ID number: _____

Current policyholder's email: _____

NEW ENROLLEE INFORMATION				
Last Name		First Name		Initial
Social Security No.		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Divorced <input type="checkbox"/> Dissolved Domestic Partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			Height	Weight
Mailing Address (street or PO box)		City		Zip
Home Address (if different)		City		Zip
Employer			Occupation	
Home Phone No.		Work Phone No.		

If enrolling a newborn or newly adopted child:

If the child's last name is different from yours, explain the child's relationship to you: _____

Does the child have other medical coverage in addition to this plan? Yes No

Name, address, phone, and policy no. of other insurance: _____

I understand that PacificSource or its designee may, while the policy is in force, examine medical, hospital, and other records pertaining to cases for which benefits are claimed and for purposes of utilization review, quality assurance, and peer review.

To the best of my knowledge, the above is complete and true. Any falsified or material misrepresentations or omissions may entitle PacificSource to rescind or cancel the policy.

Applicant Signature

Date

Parent/Guardian Signature (if applicant is a minor)

Date

PRODUCER AUTHORIZATION

I, the insurance producer, have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the policy except through written material furnished by PacificSource. The applicant has been informed that the effective date of coverage is assigned only by PacificSource. I hereby certify that information supplied to me by the applicant has been truly and accurately recorded hereon.

Producer Name (printed)

Producer Number

Producer Signature

Date

Please return this completed form to:

*Attn: Individual Sales
PacificSource Health Plans
PO Box 7068
Eugene OR 97401
Fax (541) 225-3646*

After your request is processed, you will receive a letter of confirmation and, if appropriate, new ID cards, policy document, and billing statements.