INDIVIDUAL POLICY CHANGE FORM (MT)

Add newborn or adopted child
Transfer dependent to new policy

Individual Sales Department
PO Box 7068
Springfield, OR 97475-0068
(888) 684-5585
Fax (541) 225-3646
MontanaIndividual@pacificsource.com

Please use this form only to make the changes listed below. Use a separate form for each dependant. Other changes, such as adding a spouse or other dependent (other than a newborn or newly adopted child) may require you to complete and submit a new application for review (underwriting). If you have any questions or are not sure if this is the form to use, please contact our Individual Sales Department. A representative will be happy to assist you.

Please complete, sign, date, this form, and then return it to our Individual Sales Department. After your request is processed, you will receive confirmation and, if required, a new policy, ID card, and billing statement.

ENROLLMENT CHANGE (check one) AND POLICY INFORMATION

☐ Add a newborn child within 31 days of birth

☐ Add a newly adopted child within 31 days of placement (please attach a copy of your adoption papers) Date of placement (mm/dd/yyyy): _____

☐ Transfer dependent from this policy to a separate policy with the same plan design and deductible level

Requested effective date (month and year): _____

Note: If the change above is due to a divorce, domestic partnership dissolution, or death, please indicate and provide the date:

☐ Divorce ☐ Domestic partnership dissolution ☐ Death Date (mm/dd/yyyy): _____

Policyholder name: _____ Social Security or ID num.: _____

Daytime phone: _____ Email: _____

DEPENDENT INFORMATION

Last name: _____ First name: _____ Middle initial: _____ Gender: ☐ M ☐ F

If a different last name, please explain the child's relationship to you: _____

Social Security num.: _____ Birth date (mm/dd/yyyy): _____ Height: _____ Weight: _____

Marital status: ☐ Single ☐ Married ☐ Domestic Partnership
☐ Divorced ☐ Dissolved Domestic Partnership ☐ Widowed ☐ Separated

Street address: _____ City: _____ State: _____ Zip: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Email: _____

Will your child also be covered by another medical plan? ☐ Yes ☐ No If yes, please list the other insurance:

Name, address, phone, and policy number: _____

_____

SIGNATURES

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.

Policyholder Signature	Date	Applicant Signature (if age 18 or older)	Date

Agent Signature (if applicable)	Name (printed)	Number	Date