evergreen HEALTH

Coverage Change Form [Special Enrollment Period [SEP]]

INSTRUCTIONS

1. This form is for current Evergreen Health members in an Individual Off-Exchange plan to add dependents, remove dependents, or cancel their Individual Off-Exchange plan.
2. If you purchased your health insurance through the Maryland Health Connection, please do not use this form. All requests to change your plan must be made by logging on to your account at MarylandHealthConnection.gov or by calling the Maryland Health Connection at 855-642-8577.
3. Please fill out all applicable spaces on this application. Print or type all information.
4. Sign and return this application in the postage-paid return envelope if provided, or mail or email to:

Individual Enrollment -or- **enroll@evergreenmd.org**
Evergreen Health Co-Op Subject line: Individual Off-Exchange Dependent Change Form
3000 Falls Road, Suite 1
Baltimore, MD 21211

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. **If incomplete, the application will be returned and delay your coverage**

SUBSCRIBER INFORMATION [MUST COMPLETE]			
Last Name First Name		Middle Initial	Subscriber ID #
Residence Address: [Number and Street, Apt. #] Please use your work address if you work in Maryland but do not reside in the state.		City and State	Zip Code [9-digit, if known]
Billing address, if different from residence address: [Number and Street, Apt. #]		City and State	Zip Code [9-digit, if known]
Date of Birth	Home Phone [ ]	Email	
Sex ❏ Male ❏ Female	Work/Cell Phone [ ]		

CANCEL COVERAGE

CANCELLING COVERAGE [PLEASE LIST ALL MEMBERS CANCELLING COVERAGE]						
	Last Name	First Name	MI	Member ID #	Reason for Cancelling Coverage	Requested Effective Date of Cancellation
Subscriber						
Partner/Spouse						
Dependent 1						
Dependent 2						
Dependent 3						
Dependent 4						
Dependent 5						

IT IS UNDERSTOOD AND AGREED THAT:

By signing my name below, I am cancelling coverage with Evergreen Health for all individuals listed under box 2. Evergreen Health will provide confirmation of this cancellation and the effective date of cancellation. After the effective date of cancellation, the individuals listed under box 2 will no longer have coverage with Evergreen Health and will not be entitled to any benefits from Evergreen Health. Any outstanding amounts due to Evergreen Health or providers from services received prior to cancellation of coverage for the individuals listed in box 2 will still remain due after cancellation of Evergreen Health coverage.

Signature of Subscriber ______________________________ Date ____________________

Special Enrollment

QUALIFYING EVENTS

There are certain enrollment periods, referred to as special enrollment periods, which follow a triggering event during which an **individual has sixty (60) days to enroll in an Evergreen plan.** Please complete this section if coverage is being sought during a special enrollment period. If you already have coverage under an Evergreen plan and you are adding a dependent(s) to an existing Evergreen plan during a special enrollment period, complete this section only for new dependent(s).

The following are triggering events that permit an individual to enroll in an Evergreen plan within 60 days after the triggering event, or in the case of the triggering event in Paragraphs B, G, H, I and K 60 days before and after the triggering event.

A. if the qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order;

B. loss of minimum essential coverage by the qualified individual or dependent (loss of coverage does not include termination or loss due to failure to pay premiums on a timely basis);

C. a qualified individual or dependent's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Maryland Health Benefit Exchange;

D. an individual or dependent adequately demonstrates to the Maryland Health Benefit Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

E. an individual or dependent becomes newly eligible or ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether the individual is already enrolled in a

F. qualified health plan;

G. a qualified individual or dependent gains access to new qualified health plans as a result of a permanent move;

H. individuals whose existing coverage through an employer-sponsored plan is no longer affordable or no longer provides minimum value will be permitted to gain access to a qualified health plan prior to the end of coverage through the employer-sponsored plan;

I. an individual or dependent loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act;

J. an individual or dependent loses medically needy coverage as described under section 1902(a)(10)(c) of the Social Security Act only once per calendar year;

K. the MHBE determines a qualified individual or enrollee, or dependent, was not enrolled in qualified health plan coverage, was not enrolled in the qualified health plan selected by the qualified individual or enrollee, or is eligible for but is not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-MHBE entity providing enrollment assistance or conducting enrollment activities;

L. an individual or dependent becomes eligible due to the end of the policy year for an individual or dependent covered under a non-calendar year individual or group health insurance plan;

M. an individual or dependent who was not previously a citizen, national or lawfully present individual gains such status;

N. an enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation, or if the enrollee dies.

SPECIAL ENROLLMENT CONT'D – INDIVIDUAL AND FAMILY MEMBER						
	Last Name	First Name	MI	DOB	Social Security #	Specify the triggering event and date of the triggering event that gives rise to the right to special enrollment (A through M from the above list)
Partner/Spouse						
Dependent 1						
Dependent 2						
Dependent 3						
Dependent 4						
Dependent 5						
Dependent 6						

If you have other insurance, failure to complete this section will cause significant delays in processing any claims submitted.

1. **Is anyone listed on this application eligible for or covered under any other health plan, including Medicaid and/or Medicare, or COBRA or state continuation?____________________If yes, please provide the following:**

   Name of family member(s) ____

   Plan or Carrier Name________________________________ Plan or Policy Number ________________

   Plan Phone # _____________________________________ Dates of Coverage ____________________

2. **Has anyone listed on this application exhausted COBRA or state continuation coverage under a group health plan within the past twelve (12) months? If yes, please list name(s)**

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the subscriber (or to a person authorized to act on his/her behalf) upon request, from Evergreen Health Cooperative Inc.

This information is subject to verification. To do so I authorize any physician, hospital, pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company to release my "Medical information" to Evergreen Health Cooperative Inc. or Evergreen Health Cooperative's business associates or representatives. I further authorize any business associate who receives "Medical Information" from any physician, hospital pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company to release my "Medical Information" to Evergreen Health Cooperative Inc. I understand that my Medical Information consists of any diagnoses, treatment, prescriptions from a pharmacy, or any other medically related information about me. I authorize Evergreen Health Cooperative Inc. to use my age, and geographic location when determining the cost of my insurance benefits.

This authorization shall include and apply to any and all protected health information related to treatments where I have requested a restriction to a health care provider to release information and/or for any health care item or service for which I have paid the health care provider in full. I understand this authorization will remain in effect for 30 months from the date signed.

I understand that I have the right to cancel this authorization at any time, in writing, except to the extent that Evergreen Health Cooperative Inc. has already taken action in reliance on this authorization. I also understand that Evergreen Health Cooperative Inc. notice of Privacy Practices includes information pertaining to authorizations and to requirements of revocation. A copy of the notice may be obtained by contacting the Evergreen Health Cooperative Inc.'s Privacy office.

Evergreen Health Cooperative Inc. will not use or disclose the Medical Information for any purposes other than those listed above except as may be required by law. Evergreen Health Cooperative Inc. is required to tell you by law that information disclosed pursuant to this authorization may be subject to re-disclosure and that under some limited circumstances will no longer be protected by federal privacy regulations.

If Evergreen Health Cooperative Inc. determines that additional information is needed, I will receive an authorization to release that information. Failure to execute an authorization may result in the denial of my application for coverage.

Additionally, I understand that failure to complete any section of this application, including signing below, may delay the processing of my application.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for an Evergreen Health Cooperative Inc. policy. I understand that the information provided determines the pricing of this policy.

I also understand that failure to enter accurate information may result in the denial of all benefits or cancellation of my policy. Evergreen Health Cooperative Inc. may rescind or void my coverage only if (1) I have performed an act, practice, or omission that constitutes fraud; or (2) I have made an intentional misrepresentation of material fact. Evergreen Health Cooperative Inc. will provide 30-days advance written notice of any rescission of coverage and refund any premiums

to the subscriber. In the event of rescission, the Member is responsible for repayment of any claim payment made by Evergreen Health Cooperative Inc. on the Member's behalf.

I will update Evergreen Health Cooperative Inc. if there have been any changes in geographic location for any person listed in this application that occur prior to acceptance of this application by Evergreen Health Cooperative Inc. Adding a dependent to a self-only coverage Individual Off-Exchange plan will result in the plan becoming a family coverage Individual Off-Exchange plan with a higher deductible and maximum out-of-pocket. Adding a dependent may result in a higher premium. **If you have any questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact a customer services representative before signing this application.**

WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Subscriber____ Date ______________________________

Signature of Applicant ____ Date_____________________________
(Spouse or Partner)

Signature of Eligible Dependent____
Date____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent____
Date____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent____
Date____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent____
Date____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent____
Date____
Any dependent 18 years of age or older must sign

NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian must be signed by the parent or legal guardian.

Signature of Parent or Legal Guardian______________________________________Date ______________________________