



REQUEST TO CHANGE INDIVIDUAL COVERAGE

Mail Application To:
 PO Box 1107
 1602 21st Ave.
 Lewiston, ID 83501

This form must be completed and signed in order to process this request to change your current individual coverage.

MEMBER, SPOUSE, AND DEPENDENT INFORMATION.

Please list all family members you wish to cover who are currently enrolled on your existing individual plan. Any dependents you wish to cover who are not currently enrolled must fill out a new application and health questionnaire which we may accept or reject. **(Please print)**

Name (Last, First, Middle Initial)	Social Security Number	Sex	Birth Date	Relationship to Member
			/ /	SELF
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

RESIDENCE ADDRESS

Street	City	State	Zip Code

BILLING ADDRESS (if different than residence)

Street	City	State	Zip Code

COVERAGE CHANGE REQUESTED (Please check deductible option you wish to change to)

<p>PREFERRED PLANS — Deductible Options:</p> <p>Comprehensive Catastrophic Catastrophic (H S A Qualified)</p> <p><input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 Member/\$5,000 Family</p>	<p>Asuris Claritysm Plans — Deductible Options:</p> <p>Clarity 50 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000</p> <p>Clarity 70 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$3,000</p> <p>Clarity 80 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,500</p>
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CONDITIONS OF THIS CHANGE REQUEST

By completing and signing this form, I agree to and understand the following:

- If my rates are paid current, coverage for myself and any dependents currently covered on my plan will be changed to the plan I am selecting on this form.
- A new contract will be issued and all terms and conditions of the new contract will be effective the first of the month following the receipt date of this change request unless otherwise noted.
- Any false information provided on this form may result in the retroactive termination of coverage.

- This request to change plans is dependent upon:
 - Being a resident in the Asuris Northwest Health service area, and
 - Receipt of this completed document within the timeframe which may be specified by the plan;
 - Current revision guidelines. For information regarding these guidelines, please call 1-888-344-8234.

Subscriber Signature	Date	Home Telephone Number
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NON-SMOKER CERTIFICATION STATEMENT

Complete this section if enrolling on a non-smoker plan.

<p>I certify that I have not smoked cigarettes, cigars, pipes, or used chewing tobacco, smokeless tobacco or any other form of tobacco or illegal drug substance within the past 12 months. PLEASE NOTE: The company reserves the right to cancel coverage and collect claims payments or other damages if false information is submitted or if you fail to notify us you are no longer eligible for the non-smoker discount.</p>			
_____	_____	_____	_____
Applicant's Signature	Date	Spouse's Signature (If applicable)	Date

AGENT INFORMATION

IF APPLICATION IS BEING MADE THROUGH AN AGENT, HE/SHE MUST COMPLETE THE INFORMATION REQUESTED BELOW.

NOTE: Agents who do not have a current appointment with Asuris Northwest Health are not authorized to enroll members. Agents requesting to change members from PPO Comprehensive and Catastrophic plans, to Asuris Clarity plans are not eligible for the monthly broker bonus.

Agent Name	Firm or Agency		
Agent Address			Agent Telephone Number
<p>I certify I have verified that all persons applying for coverage are eligible. I further certify, to the best of my knowledge, the information on this application has been completed truthfully by the applicant(s).</p>			
_____		_____	
Agent Signature		Date	
Agent's Washington State License Number	Expiration Date	Asuris Northwest Health Agent Number	
Contact Person			