INCLUSIVE HEALTH
FEDERAL OPTION

FOR OFFICE USE ONLY
Approved by:

Effective Date:

CHANGE FORM

Applicant Information: (ALL members must complete this section) –

Last Name	First Name	Middle Initial		
Address	**City**	**County**	**State**	**Zip code**
Member ID #	**Date of Bird**	**Telephone #**	**Email Address**	

☐ **Address Change -** Is the address provided above a new address?

☐ **Coverage Change -** (Changes in coverage will be effective on the anniversary date of your current policy):

- ☐ **PPO 1000 - $1000 deductible**
- ☐ **PPO 2500 - $2500 deductible**
- ☐ **PPO 3500 - $3500 deductible**
- ☐ **High Deductible 4500 - $4500 deductible**

**** More information on the each plan can be found at:**
http://www.inclusivehealth.org/federaloption/coverage.htm

☐ **Smoker/ Non-Smoker rate change**

I HAVE _____ or HAVE NOT _____ smoked cigarettes, cigars, used a pipe or chewing tobacco, nicotine chewing gum or snuff in the last 12 months
(This change must be accompanied by a Doctor's statement)

☐ **Cancellation of Coverage -** I wish to cancel my current health insurance coverage under Inclusive Health – Federal Option to be effective on: _____

My reason for cancellation is: Too expensive ___ Obtained Group Coverage ___ Medicare eligible ___
Moved ___ Other individual coverage ___ Other: _____

☐ **Change in Employment Status -** I changed employment effective: _____

Name of Employer _____ Does this company offer health insurance: ☐ Yes ☐ No

Are you eligible and enrolled in this insurance? ☐ Yes ☐ No If No, why not: _____

☐ **I do not wish to make any changes to my coverage at this time**

I hereby certify the forgoing statements are true and accurate to the best of my knowledge and belief. I understand that no change will become effective until approval by Inclusive Health. I understand that if I obtain other health insurance coverage including Medicare, Medicaid, SCHIP or other group coverage or move out of the state of North Carolina, I must notify Inclusive Health and my Inclusive Health benefits will end.

_____ _____ _____

Signature of the Member **Date** **Signature of Parent or Legal Guardian**

Mail this form to: **Inclusive Health PO Box 2302 Mt. Clemens, MI 48046-2302**

Email Address: Contactus_Federal@inclusivehealth.org **Website:** www.inclusivehealth.org **Customer Service – (866) 665-2117**

Failure to complete and return this form with any changes will result in your current plan option remaining the same as it currently is and you will not be able to make any changes until your next open enrollment period.
