meritus

Add/Change/Cancellation Form

Instructions

Please use this form to complete the following changes:

- Address change
- Name change or correction
- Plan change
- Network change*
- Termination**

* Any plan changes must stay in the same metal level, and be an increase in price and network size. An example would be changing from the MIHS network (a narrow network) to an HMO Complete network (a larger HMO network).

****Only OFF-Marketplace plans can be terminated with this form.** Subsidized ON-Marketplace plans can only be canceled by the main subscriber by calling 1.800.318.2596 or through the Healthcare.gov website by logging in to their account and canceling the plan.

Please have your client fill out this form, sign it and have your office email it to: Enrollmentchanges@MeritusAZ.com

IT IS CRITICAL TO COMPLETE THE FOLLOWING AREAS

1) Fill in the first and last name and member number information.

First Name	M.I.	Last Name	Social Security Number	Meritus Member ID

If the member number ID is unknown, leave this field blank, but to accurately identify the member, include date of birth and address.

2) If they are changing plans, please check the NEW plan.

HMO	
☐ Meritus Healthy Platinum Complete HMO Plus 500 – QHP#: 60761AZ069	☐ Meritus Healthy Silver HMO Banner 4000 – QHP#: 60761AZ027
☐ Meritus Healthy Platinum HMO Plus Abrazo 500 – QHP#: 60761AZ072	☐ Meritus Healthy Silver HMO MIHS 4000 – QHP#: 60761AZ030
☐ Meritus Healthy Platinum HMO Plus Banner 500 – QHP#: 60761AZ071	☐ Meritus Healthy Silver HMO Mohave 4000 – QHP#: 60761AZ031
☐ Meritus Healthy Platinum HMO Plus Mohave 500 – QHP#: 60761AZ074	☐ Meritus Healthy Silver HMO Pima 4000 – QHP#: 60761AZ029
☐ Meritus Healthy Platinum HMO Plus Pima 500 – QHP#: 60761AZ073	☐ Meritus Neighborhood Network Silver HMO MIHS – QHP#: 60761AZ008
☐ Meritus Healthy Gold Complete HMO Plus 2000 – QHP#: 60761AZ033	☐ Meritus Community Network Silver HMO Banner – QHP#: 60761AZ009
☐ Meritus Healthy Gold HMO Plus Abrazo 2000 – QHP#: 60761AZ035	☐ Meritus Community Network Silver HMO Pima – QHP#: 60761AZ010
☐ Meritus Healthy Gold HMO Plus Banner 2000 – QHP#: 60761AZ034	☐ Meritus Healthy Bronze Complete HMO 6000 – QHP#: 60761AZ020
☐ Meritus Healthy Gold HMO Plus Mohave 2000 – QHP#: 60761AZ037	☐ Meritus Healthy Bronze HMO Abrazo 6000 – QHP#: 60761AZ022
☐ Meritus Healthy Gold HMO Plus Pima 2000 – QHP#: 60761AZ036	☐ Meritus Healthy Bronze HMO Banner 6000 – QHP#: 60761AZ021
☐ Meritus Healthy Silver Complete HMO 4000 – QHP#: 60761AZ026	☐ Meritus Healthy Bronze HMO Mohave 6000 – QHP#: 60761AZ024
☐ Meritus Healthy Silver HMO Abrazo 4000 – QHP#: 60761AZ028	☐ Meritus Healthy Bronze HMO Pima 6000 – QHP#: 60761AZ023
PPO	
☐ Meritus Choice Gold PPO Plus 2000 – QHP#: 92045AZ028	☐ Meritus Saver Gold PPO HSA Plus 1500 – QHP#: 92045AZ031
☐ Meritus Choice Silver PPO Plus 4000 – QHP#: 92045AZ027	☐ Meritus Saver Silver PPO Plus 2000 – QHP#: 92045AZ030
☐ Meritus Choice Bronze PPO Plus 6000 – QHP#: 92045AZ026	☐ Meritus Saver Bronze PPO Plus 6300 – QHP#: 92045AZ029

3) Complete the "Reason for plan change" section and tell us the reason for cancelling. Please include the current plan name, the new plan name, date of change/termination – i.e. 3/1/15* and reason for the change (ie. "Network was too restrictive").

Reason for plan change, if not open enrollment:

Change Plan (Subscriber & Dependents): From Current Plan_____ to New Plan _____

Effective Date of Change: ___/___/___ Reason for Plan Change _____

4) Sign and date the third page where indicated.

If the effective date is 3/1/15, the customer need to pay any additional premium between the current plan and the new plan/network.

5) When the form is completed and signed, please have your office (not the client) email the form to: Enrollmentchanges@MeritusAZ.com

NOTE: Changes take 30 days or one complete billing cycle to be reflected on billing statement, member portal and ID Cards.

meritus HEALTH PARTNERS

INDIVIDUAL PLAN
Add/Change/Cancellation Form

2005 West 14th Street, Suite 113
Tempe, AZ 85281

Check Box if Applicable and Complete Corresponding Section

First Name	M.I.	Last Name	Social Security Number	Meritus Member ID

☐ **NAME CHANGE**

First Name	M.I.	Last Name

☐ **ADDRESS CHANGE**

New Home Address - Street	City	State	Zip Code	County

New Primary Phone (Include Area Code)		New Secondary Phone (Include Area Code)	

DISCLAIMER: Moving from one county to another county may result in a monthly premium change.

HMO

☐ Meritus Healthy Platinum Complete HMO Plus 500 – QHP#: 60761AZ069	☐ Meritus Healthy Silver HMO Banner 4000 – QHP#: 60761AZ027
☐ Meritus Healthy Platinum HMO Plus Abrazo 500 – QHP#: 60761AZ072	☐ Meritus Healthy Silver HMO MIHS 4000 – QHP#: 60761AZ030
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☐ Meritus Healthy Platinum HMO Plus Mohave 500 – QHP#: 60761AZ074	☐ Meritus Healthy Silver HMO Pima 4000 – QHP#: 60761AZ029
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☐ Meritus Healthy Silver HMO Abrazo 4000 – QHP#: 60761AZ028	☐ Meritus Healthy Bronze HMO Pima 6000 – QHP#: 60761AZ023

PPO

☐ Meritus Choice Gold PPO Plus 2000 – QHP#: 92045AZ028	☐ Meritus Saver Gold PPO HSA Plus 1500 – QHP#: 92045AZ031
☐ Meritus Choice Silver PPO Plus 4000 – QHP#: 92045AZ027	☐ Meritus Saver Silver PPO Plus 2000 – QHP#: 92045AZ030
☐ Meritus Choice Bronze PPO Plus 6000 – QHP#: 92045AZ026	☐ Meritus Saver Bronze PPO Plus 6300 – QHP#: 92045AZ029

Reason for plan change, if not open enrollment:

Change Plan (Subscriber & Dependents): From Current Plan_____ to New Plan _____

Effective Date of Change: ____/____/____ Reason for Plan Change _____

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INDIVIDUAL PLAN
Add/Change/Cancellation Form

2005 West 14th Street, Suite 113
Tempe, AZ 85281

Term Code	Name (First, MI, Last)	Social Security Number	Primary Care Provider (PCP) (for HMO Plans Only)	Date Of Birth (MM/DD/YYYY)	Relationship	Gender (M / F)	Race

Reason for addition, if not open enrollment:

Birth ☐ Date of Birth:____/____/____ | Adoption ☐ Date of Adoption:____/____/____ | Legal Guardianship ☐ Date of Legal Guardianship:____/____/____

Marriage ☐ Marriage Date:____/____/____ | Divorce ☐ Date of Divorce:____/____/____ | Policy Termination: ☐ Date of Term:____/____/____

Other:_____ Date of Event:____/____/____

Reason for termination, if not open enrollment:

Policy Termination: ☐ Reason Code_____ Date of Term:____/____/____ Other:_____ Date of Event:____/____/____

Term Codes: A – Deceased B – Divorced C – Eligible for other coverage D – Dependent Ineligible E – Change in Employment Status

Tobacco Use:* Has any person to be **covered**, and who may legally use tobacco under federal or state law, smoked or used any tobacco product on an average of four or more times per week within the past 6 months (this does not include tobacco use for religious or ceremonial use)? ***Please provide information below*:**

Name	*Tobacco Use (Average 4x / Week in Past 6 Months)?	Type of Tobacco Product	How Often?	How Much?	Last Date of Use (MM/DD/YYYY)
	Yes ☐ No ☐				
	Yes ☐ No ☐				
	Yes ☐ No ☐				

Will anyone be enrolled in other health coverage as of the effective date of this policy? Yes ☐ No ☐

☐ **CUSTODIAL ADDRESS CHANGE FOR DEPENDENT(S)** ***For legal dependents not living with Subscriber***

List Name/Date of Birth for Dependents with New Address	

New Home Address - Street City State Zip Code County

New Primary Phone (Include Area Code)		New Secondary Phone (Include Area Code)	

I hereby apply for coverage on the basis of the statements and answers to the questions herein. I hereby represent all answers to be true to the best of my knowledge and to accurately represent those persons applying for coverage and waiving coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage. I UNDERSTAND THAT IF MY APPLICATION FOR NEW OR ADDITIONAL COVERAGE IS ACCEPTED, THAT APPLICABLE COVERAGE WILL NOT BE EFFECTIVE UNTIL AFTER I AM NOTIFIED OF THE EFFECTIVE DATE.

I hereby authorize Meritus Health Partners to obtain from providers of services and hospitals, including those providers with whom Meritus Health Partners contracts for service, the medical records, including those which relate to mental health and chemical dependency treatment, relating to me and my family members to the extent that those records are necessary for enrollment as well as for the administration of the Meritus Health Partner contract, including for purposes of claims payment, case management, fraud investigation and quality of care review. A photocopy of this authorization shall be as valid as the original and remains in effect as long as continually insured by Meritus Health Partners or until revoked.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION TO MERITUS HEALTH PARTNERS IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OR RESCISSION OF COVERAGE.

SIGNATURE OF APPLICANT | DATE SIGNED

V. Applicant's Authorization for Termination or Cancellation

I hereby request termination/cancellation of coverage effective as of the date requested in SECTION III. I UNDERSTAND THAT MY APPLICATION FOR TERMINATING/CANCELLING COVERAGE WILL NOT BE EFFECTIVE UNTIL APPROVED BY MERITUS, AND I WILL BE NOTIFIED OF ANY PREMIUM ADJUSTMENT DUE TO THE TERMINATION.

SIGNATURE OF APPLICANT | DATE SIGNED

VI. MERITUS use only

Plan Origination ☐ CMSFFM ☐ OI	CSR ☐ 73% ☐ 87% ☐ 94%	QHP Plan ID	Current Premium	New Premium	APTC ☐
Meritus Approval			Net Premium Due from Subscriber: +/-	$	