

## SOLO Health Care Plan Change Form

Subscriber Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_  
 Address: \_\_\_\_\_ County: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**1. Have you or any covered family member used tobacco in the last 12 months?**  Yes  No

If Yes, give person's name: \_\_\_\_\_

**2. Change plan** — Please choose from among the following plan options:

<p><b>Choose Plan:</b></p> <p><input type="checkbox"/> SOLO View  <input type="checkbox"/> SOLO Outlook</p> <p>Go to needsolo.org for Outlook premium quote</p> <p><b>Choose Plan Deductible Option:</b></p> <p><input type="checkbox"/> SOLO \$500  <input type="checkbox"/> SOLO \$1,500  <input type="checkbox"/> SOLO \$2,500  <input type="checkbox"/> SOLO \$4,000  <input type="checkbox"/> ACTIVE \$7,500  <input type="checkbox"/> ACTIVE \$10,000</p>	<p style="text-align: center;"><b>Prescription Drug Rider</b></p> <p>\$15 copay for Generic drugs is included in the plan unless another option is selected.</p> <p><input type="checkbox"/> <b>Discount Plan</b> – You pay 100% of the RMHP discounted rate for prescription drugs</p> <p><input type="checkbox"/> <b>Brand Name Drug Rider</b> \$15 / \$40 / \$60</p> <p><input type="checkbox"/> <b>Brand Name with \$250 Deductible Rider</b> \$15 Generic copay (no deductible) \$40 / \$60 Brand Name copay after \$250 deductible</p>	<p style="text-align: center;"><b>Optional Accident Rider</b></p> <p><input type="checkbox"/> <b>Optional Accident Rider</b> Go to needsolo.org for benefit and rate information</p>	<p><b>Choose Plan:</b></p> <p><input type="checkbox"/> SOLO HSA View  <input type="checkbox"/> SOLO HSA Outlook</p> <p>Go to needsolo.org for Outlook HSA premium quote</p> <p><b>Choose Plan Deductible Option:</b></p> <p><input type="checkbox"/> SOLO HSA \$2,500  <input type="checkbox"/> SOLO HSA \$3,250  <input type="checkbox"/> SOLO HSA \$5,000</p>	<p style="text-align: center;"><b>Prescription Drug Rider</b></p> <p>Generic prescription drug coverage is included with the plan and covered at 100% after deductible.</p> <p><input type="checkbox"/> <b>Brand Name Drug Rider</b> Generic and Brand Name prescription drugs are covered at 100% after deductible.</p>	<p style="text-align: center;"><b>Optional Accident Rider</b></p> <p><input type="checkbox"/> <b>Optional Accident Rider</b> \$1 to \$1,000 covered in full for each accident, then deductible and coinsurance apply.</p>
Additional Information: _____					

**3. Have you or any covered family member taken any prescription medications in the last 12 months?**  Yes  No

If yes, complete the chart below. Add and label another page if necessary.

Family Member	Medication Name	Quantity/ Dosage Taken	Prescribing Physician	Illness for Which Medication Prescribed	Date Prescription Last Received

**4. Have you or any covered family member been advised or are planning to have medical or surgical treatment that has not yet been performed?**

Yes  No If yes, please explain. Person's name and planned treatment: \_\_\_\_\_

**5. At this time, are you or your spouse pregnant, expecting a child, or in the process of adoption?**  Yes  No

The undersigned individually and on behalf of the undersigned's dependents agrees as follows:

- a) I agree that enrollment, eligibility, coverage, and benefits in my health plan are subject to applicable policies and requirements and to all terms of the applicable contract for my health plan.
- b) I agree that the above information is true, and I authorize the above change.
- c) I understand that the above-requested benefit change may be subject to medical underwriting and is not an automatic change.
- d) I agree that the approved plan change will be effective on my anniversary date or on the first of the month following approval. I agree to continue to pay premium on my current SOLO plan while this plan change request is processed.
- e) I understand a plan change to a SOLO Outlook plan is subject to medical underwriting and rates are based on the health status of each enrolled family member.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_