SHARP HEALTH PLAN
make life better.®

Individual & Family Plan

Account Change Form

Instructions

Fill out this form if you would like to make changes to your benefit plan, or update the personal information associated with your account.

You can make changes to the following:

- Your Subscriber Information
- Your Coverage
- Your Benefit Plan and Network

Covered California Members: To add a dependent or change your benefit plan, please contact Covered CA at 1-800-300-1506. You can also change or update your account online by logging in to your Covered CA account at **coveredca.com**.

Submit

Please submit the finished form by mail, in person*, or fax:

By Mail or In Person*:
Sharp Health Plan
Attention: IFP Sales
8520 Tech Way, Suite 200
San Diego, CA 92123

By Fax:
Attention: IFP Sales
(858) 499-8246

If you need assistance, we're here to help.

You can call Customer Care at (858) 499-8300 or toll-free at 1-800-359-2002.
We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

Step 1. Subscriber Information

☐ **Check box if your name, address or phone number has changed.**

First name:		Middle initial:
Last name:		Phone number: ( )
Subscriber ID (starting with the number 92):	Social Security Number: – –	Birth date (MM/DD/YY): / /
Email:		
Home address (P.O. Box is not allowed):		
City:	State:	ZIP Code:
Billing Address (If different from above): ☐ Check if the same as your home address.		
City:	State:	ZIP Code:
Primary Care Physician (PCP) Information: (If left blank, Sharp Health Plan will assign a PCP.)		
Name:	Provider ID:	Are you an existing patient with this doctor? ☐ Yes ☐ No doctor

*Pending safety guidelines

Step 2: Changes to Coverage

1. When are you making a change to your coverage?

☐ During Open Enrollment (Nov 1, 2020 to Jan 31, 2021). ☐ During a Special Enrollment Period.

If you selected "During a Special Enrollment Period," check the box next to your qualifying event:

- ☐ Loss of health care coverage
- ☐ Gaining or becoming a dependent through marriage or domestic partnership registration
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, foster care, or placement for adoption or foster care
  (Please choose your effective date, MM/DD/YY):
  (/ /)
  - ☐ The date of birth, adoption, foster care, or placement for adoption or foster care
  - ☐ The first day of the month after gaining the dependent
- ☐ Losing a dependent through divorce, dissolution
- ☐ Death of the subscriber or a dependent
- ☐ Child support order or other court order to cover a dependent
- ☐ Permanent relocation in or out of the service area
- ☐ Release from incarceration
- ☐ Change in eligibility for federal financial assistance through Covered California*
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by Covered California
- ☐ Misinformation about coverage
- ☐ Provider network changes
- ☐ Health coverage issuer substantially violated a material provision of the health coverage contract
- ☐ Member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service

Date of qualifying event (MM/DD/YYYY): / /

* If you may be eligible for federal financial assistance, don't use this form. Instead, you'll need to report a change through Covered CA. Please call Covered CA at 1-800-300-1506, or log in to your online account at **coveredca.com**.

2. What change(s) do you want to make to your coverage?

Check the boxes for the changes you would like to make:

Add Coverage

- ☐ I wish to add medical coverage for a family member.

Changes to Account/Coverage

- ☐ I wish to switch the subscriber and spouse/domestic partner roles on our current plan.
- ☐ I wish to combine accounts. Select your Benefit Plan on page 4.
- ☐ I wish to change Benefit Plans. Select your Benefit Plan on page 4.

3. Who will be affected by these changes to your coverage?

If you have more than 3 dependents affected by these changes, please attach another form with the following information filled out for each additional dependent. **You will need to select a Primary Care Physician (PCP) for each person included on your Benefit Plan.** Remember, you receive Covered Benefits from Plan Providers who are affiliated with your Plan Medical Group (PMG) and who are part of your Plan Network. The Benefit Plan you choose will determine the doctors that are available to you. You will need to ensure that the PCP you select is affiliated with the PMG for your Benefit Plan. To find a Sharp Health Plan doctor who meets your needs, visit **sharphealthplan.com/findadoctor**, or call Customer Care toll-free at 1-800-359-2002.

Spouse/Domestic Partner	☐ Add medical coverage ☐ End medical coverage		
First name:	Middle initial:	Last name:	Sex: ☐ M ☐ F
ID# (starting with the number 92):	Social Security Number: – –	Birth date (MM/DD/YY): / /	
Primary Care Physician (PCP) Information: (If left blank, Sharp Health Plan will assign a PCP.)			
Name:	Provider NPI-:	Is your Spouse/Domestic Partner an existing patient with this doctor? ☐ Yes ☐ No	

Dependent 1	☐ Add medical coverage ☐ End medical coverage		
First name:	Middle initial:	Last name:	Sex: ☐ M ☐ F
ID# (starting with the number 92):	Social Security Number: – –	Birth date (MM/DD/YY): / /	
Primary Care Physician (PCP) Information: (If left blank, Sharp Health Plan will assign a PCP.)			
Name:	Provider ID:	Is Dependent 1 an existing patient with this doctor? ☐ Yes ☐ No	

Dependent 2	☐ Add medical coverage ☐ End medical coverage		
First name:	Middle initial:	Last name:	Sex: ☐ M ☐ F
ID# (starting with the number 92):	Social Security Number: – –	Birth date (MM/DD/YY): / /	
Primary Care Physician (PCP) Information: (If left blank, Sharp Health Plan will assign a PCP.)			
Name:	Provider ID:	Is Dependent 2 an existing patient with this doctor? ☐ Yes ☐ No	

Dependent 3	☐ Add medical coverage ☐ End medical coverage		
First name:	Middle initial:	Last name:	Sex: ☐ M ☐ F
ID# (starting with the number 92):	Social Security Number: – –	Birth date (MM/DD/YY): / /	
Primary Care Physician (PCP) Information: (If left blank, Sharp Health Plan will assign a PCP.)			
Name:	Provider ID:	Is Dependent 3 an existing patient with this doctor? ☐ Yes ☐ No	

Step 3. Plan Selection

When selecting a Benefit Plan, you must make sure that you either live or work in a ZIP code that is within that plan's Network. To find a list of ZIP codes associated with each network, please visit **sharphealthplan.com/networks-by-zip**.

Remember, you receive Covered Benefits from Plan Providers who are affiliated with your Plan Medical Group (PMG) and who are part of your Plan Network. The Benefit Plan you choose will determine the doctors that are available to you. **If you are changing your Benefit Plan, please ensure that your PCP will still be in your network. If not, you will need to select a new one.**

To see if your PCP is still in Network, or to select a new one, please visit **sharphealthplan.com/findadoctor**. You can also call Customer Care toll-free at 1-800-359-2002.

Once you have confirmed your Network, check the box next to your selected Benefit Plan from the list below:

Premier Network	
Plan Name	**Metal Tier**
☐ Sharp Platinum 90 Premier HMO	Platinum
☐ Sharp Gold 80 Premier HMO	Gold
☐ Sharp Silver 70 Off Exchange Premier HMO	Silver
☐ Sharp Bronze 60 HDHP Premier HMO	Bronze

Performance Network	
Plan Name	**Metal Tier**
☐ Sharp Platinum 90 Performance HMO	Platinum
☐ Sharp Gold 80 Performance HMO	Gold
☐ Sharp Silver 70 Off-Exchange Performance HMO	Silver
☐ Sharp Bronze 60 HMO Performance HMO	Bronze
☐ Sharp Minimum Coverage Performance HMO	Minimum Coverage

Step 4. Disclosures and Signatures

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide their own signature on the following page. Keep a copy of this application for your records.

Delta Dental of California

I understand that if I have indicated that coverage under the Plan is to be provided only for the dependent child on this form, I am responsible for payment of the required Premium and compliance with all of the provisions and conditions of the Disclosure Form / Contract.

RIGHT OF REIMBURSEMENT: I, on my behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Delta Dental of California are the primary financial responsibility of another party because of other dental coverage, I will fully inform Delta Dental of California and will execute such assignments, liens or other documents which may be necessary to enable Delta Dental of California to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

Sharp Health Plan Disclosures

- I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application is accurate, true and complete. If Sharp Health Plan determines that there is fraud (by act, practice or omission) or an intentional misrepresentation of material fact in the information on this application, I understand that coverage may be rescinded as allowed by law.
- Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.
- In accordance with the disclosure requirements of California Health & Safety Code, Section 1363 (h), this is to advise you that Sharp Health Plans' ratio of health care expenses to premiums received for the last fiscal year with respect to the Sharp Health Plan Individual & Family Plans was 81.6%.

(continued on next page)

Disclosures and Signatures, continued

- I understand that I may be subject to an audit by Sharp Health Plan, at which time I will need to provide proof of residency, date of birth and dependent eligibility (if applicable). I further understand that I must provide Sharp Health Plan with any new information that arises after the submission of this application but before my enrollment with Sharp Health Plan begins.
- I understand that this plan will only cover services provided through my plan's network of providers and facilities, unless I receive prior written authorization from Sharp Health Plan, or unless the services are emergency care services or out-of-area urgent care.
- If I indicated in Step 1 that I have a language preference other than English and have completed the English version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.
- I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.
- Depending on income level and family size, I understand that I may be eligible for financial assistance to help pay for health coverage if I purchase my coverage through Covered California. Sharp Health Plan benefit plans are available through Covered California. I must apply during an open or special enrollment period. Open enrollment is from November 1st through December 15th. The special enrollment period for all individuals enrolling through Covered California is from December 16th through January 31st. An application submitted during this special enrollment period will be treated the same as an application submitted during the open enrollment period. However, I understand that in order for coverage to begin on January 1st, I must submit my application on or before December 15th of the preceding calendar year. If I have a life change such as marriage, divorce, a new child or loss of a job, I can apply at the time the life change occurs ("special enrollment period").
- **I understand that I have the right to use Sharp Health Plan's internal dispute resolution process if any dispute or controversy arises regarding the performance, interpretation, or breach of the agreement between myself (and/or enrolled dependent) and Sharp Health Plan, whether in contract, tort, or otherwise. If I am unsatisfied with the result of the dispute resolution process, I understand that I have the right to voluntary binding arbitration, which is the final step for resolving complaints. Upon receipt of a demand for arbitration, Sharp Health Plan agrees to utilize a neutral arbiter from an appropriate entity. Arbitration will be conducted in accordance with the rules and regulations of the chosen entity.**

Subscriber/new subscriber (or person financially responsible for Subscriber if under 18):

Name:	Signature: **x**	Date (MM/DD/YY): / /

Spouse/domestic partner (if applicable)

Name:	Signature: **x**	Date (MM/DD/YY): / /

Dependent 1 (over 18, if applicable):

Name:	Signature: **x**	Date (MM/DD/YY): / /

Dependent 2 (over 18, if applicable):

Name:	Signature: **x**	Date (MM/DD/YY): / /

Dependent 3 (over 18, if applicable):

Name:	Signature: **x**	Date (MM/DD/YY): / /

Nondiscrimination Notice

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (such as large print, audio, accessible electronic formats or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711) Fax: 1-619-740-8572

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance / Appeal form on the plan's website **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

The California Department of Managed Health Care is responsible for regulating health care service plans. If your grievance has not been satisfactorily resolved by Sharp Health Plan or your grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Health Care for assistance:

- 1-888-466-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online: **www.dmhc.ca.gov**

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

English:
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish):
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (Chinese):
注意 ： 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711).。

Tiếng Việt (Vietnamese):
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

(Farsi): فارسی

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با (TTY:711) 1-800-359-2002 تماس بگیرید.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 711).

日本語 (Japanese):
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

(Arabic): العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-359-2002 (رقم
هاتف الصم والبكم :711).

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY:711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।

ภาษาไทย **(Thai):**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).