

**LIFE CHANGES REPORT FORM**

**COFA Premium Assistance Program**

Use this form to tell us about the life changes that you or other household members have experienced in the past 60 days (including the addition of new household members). NOTE: You must first report these changes to HealthCare.gov. For information or help completing this form, call the Oregon Health Insurance Marketplace at **1-855-268-3767** (toll-free).

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| PROGRAM enrollee INFORMATION | | | | | | |
| Full name (first, middle, last, and suffix): | | Maiden or other name: | | | Social Security number:      –    – | |
| Daytime phone: | Alternate phone: | | Email: | | | |
| Home address: | | City: | | State: | | ZIP code: |
| Mailing address *(if different than home address)*: | | City: | | State: | | ZIP code: |

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| LIFE CHANGES REPORTED TO HEALTHCARE.GOV |
| Check the box next to any of the following life changes that you or members of your household have experienced since applying for a program-approved plan via HealthCare.gov or since you last reported changes. |
| 🞎 I have changes to my name, date of birth, or Social Security number. |
| 🞎 I have changes to my Oregon address. |
| 🞎 My household income is different than what I reported on my application. |
| 🞎 I am now offered health insurance through my job, my spouse’s job, or my parent’s job. |
| 🞎 I am now eligible for Medicaid, Medicare, or health insurance through the U.S. Department of Veterans  Affairs or TRICARE. |
| 🞎 I am no longer eligible for Medicaid, Medicare, or health insurance through the U.S. Department of  Veterans Affairs or TRICARE. |
| 🞎 We have added or lost a member of our household from one of the following ways: birth or adoption,  placing a child for adoption or foster care, marriage or divorce, a child on my plan is turning 26, death,   or gaining or losing a dependent another way. |
| 🞎 I turned 26 and am no longer eligible to be on my parent’s health insurance policy. |
| 🞎 I have changes in my disability status, tax filing status, citizenship or immigration status, or incarceration  or release from incarceration. |

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| **important: Please attach a copy of your new eligibility result**  **from your HealthCare.gov account.** | | | |
| SIGNATURE | | |
| By my or my authorized representative’s signature below, I, the program enrollee, attest that the information on this form is true, correct, and complete to the best of my knowledge. I know I may be subject to penalties under federal and state law if I have provided false and or untrue information. | | |
| Signature: | | Date: |
| Print name: | | |
| If you have an authorized representative, that person may sign for you. If you **are** the authorized representative, you may sign here only if you and the program enrollee have completed and submitted a signed Authorized Representative form. | | |
| Authorized representative’s signature: | | Date: |
| Printed name: | Phone: | |

**NOTE:** It is important to provide life change information as soon as possible after the change has taken place. Remember that you must first report your change to HealthCare.gov and receive a new eligibility notice. You will then submit your Healthcare.gov eligibility notice and this form by mail or fax right away. Any changes not reported may result in you losing COFA Premium Assistance Program benefits or having to repay benefits.

**PLEASE MAIL OR FAX THIS FORM AND SUPPORTING DOCUMENTS TO:**

**Mail: Oregon Health Insurance Marketplace**  
Attn: COFA Premium Assistance Program  
P.O. Box 14480  
Salem, OR 97309

**Fax:** 503-947-7092