WSHIP
WASHINGTON STATE HEALTH INSURANCE POOL

PO Box 780548
San Antonio, TX 78278
www.wship.org

Questions? Call or Email 1-888-277-9135
WSHIP_Eligibility.T8@90degreebenefits.com

Plan Change Form

Return by December 15, 2026

This form is used to change plans during open enrollment for coverage that will begin January 1st of the following year. **To change plans, you must select a plan that has the same or higher deductible as your current plan.** (Your current plan and deductible are displayed above for quick reference.)

Check the box below for the plan you want to change to effective January 1, 2027:

- ❒ **I DO NOT want to change my plan for 2027** (Returning this form is optional if you do not want to change plans. If the form is not returned, your coverage will remain under your current plan.)
- ❒ **Preferred Provider Plan** $500 deductible
- ❒ **Preferred Provider Plan** $1,000 deductible
- ❒ **Preferred Provider Plan** $2,500 deductible
- ❒ **Preferred Provider Plan** $5,000 deductible
- ❒ **HSA Qualified Preferred Provider Plan** $3,000 combined medical / pharmacy deductible

If you have any questions concerning changes you might be considering, please call WSHIP customer service at **1-888-277-9135** or Email **WSHIP_Eligibility.T8@90degreebenefits.com**.

If you do not return this form, you will remain enrolled in your current plan and cannot elect to change plans until the next open enrollment period. To change plans, this form must be **SIGNED** and **RETURNED PRIOR TO DECEMBER 15, 2026**.

By signing this form, I certify the following:

I understand that I may only change to a plan that has the same or higher deductible as my current plan and that I will not be able to decrease my deductible in the future.

X _____ _____

Signature **Date Signed**

_____ _____

Printed Name **Enrollee ID #**