

CHANGE/CANCELLATION FORM

Please complete applicable sections, including your signature.
Use blue or black ink only, and be sure all copies are legible.



Check box if applicable and complete corresponding section

Subscriber's Last Name: _____ First Name: _____ M.I.: _____ HN ID #: _____ Business Phone #: _____ Extension: _____

New Address: _____ Street: _____ City: _____ State: _____ Zip: _____

Old Name: _____ New Home Phone #: _____

Change Address

Change Name

Old Name: _____ New Name: _____

Term Code**	Relationship to You:	Last Name:	First Name:	M.I.:	Social Security #:	Sex M F	Date of Birth MO DAY YR	Name of Primary Care Physician:	Access Number:

Add Dependent

Delete Dependent

Change Primary Care Physician

Reason for addition or deletion, if not open enrollment: _____

Marriage Marriage Date: _____ / _____ / _____ Divorce Divorce Date: _____ / _____ / _____

Indicate Subscriber/Dependent Who Has Other Coverage:

Is your spouse employed? If yes, list employer's name and address: _____

YES NO If yes, list spouse's business phone: _____

Are your dependents covered by other health insurance? YES NO If yes, list other health insurance company and policy number: _____

Please list names of family members, including yourself, who are eligible for Medicare: _____

List those who are disabled: _____

Terminate Contract (Subscriber & Dependents)

Term Code*: _____ (Required - See term codes in box at right)

Reason for Reinstatement: _____

Reinstatement Contract (Subscriber & Dependents)

From: Group Number _____ To: Group Number _____

From: Sub Group # _____ To: Sub Group # _____

Transfer Contract (Subscriber & Dependents)

From Plan #: _____ To Plan #: _____ Effective Date: _____

Other

Signature: _____ Date: _____

Subscriber's Signature

EMPLOYER INFORMATION

Effective Date of Change/Cancellation: _____

MO	DAY	YR
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Group #: _____ Subgroup: _____ Plan Code: _____

Employer Name: _____ Employer Signature: _____ Date: _____

*TERM CODES(Use for deleting dependents or contract)

A-Left employment/change of employment status

B-Deceased

C-Retired

D-Transferred to another insurance

E-Moved out of area

N-Divorced

T-Dependent Ineligible

V-Termination of continuation options (COBRA or state extension)

X-Laid off