Health First Health Plans
Underwritten by Health First Commercial Plans

2018 Change/Termination Form

for Individual and Family contracts

Please print using black ink. Initial all corrections. All questions must be answered.
If you enrolled through the Federal Marketplace Changes or Terminations must be made through the Federal Marketplace (healthcare.gov or 1.800.318.2596).

Section 1. Type of Transaction *(Check all that apply)*

___ Change name/address/phone

___ Add dependent(s)—Adding a dependent outside of Open Enrollment Period requires a Special Enrollment Period event. Please check one:

___ Loss of other coverage
___ Denial of Medicaid or CHIP
___ Marriage
___ Newborn
___ Other_____

Date of SEP event: _____

Effective date of coverage:_____

___ Terminate coverage

___ For contract holder and all covered dependents
___ Only for those dependents listed in Section 3
___ Contract holder only (spouse/dependents remain)

Reason:

___ Voluntary cancellation (Reason:_____)
___ Moved from service area ___ Deceased
___ Other qualifying event:_____

Date for coverage to end: _____

Section 2. Primary Contract Holder Information

Contract Holder SSN	Member ID:	First Name:	M.I.	Last Name:

Home Address:	Apt. #:	City:	State:	Zip:
Mailing Address (if different than above):	**Apt. #:**	**City:**	**State:**	**Zip:**

Phone #:	Cell Phone #:	Email Address:

Date of Birth (mm/dd/yyyy):	Sex: ___ Male ___ Female	Plan Name:	Occupation:	Language:

Section 3. Add / Change / Termination Information

(Must attach copy of supporting documentation for qualifying event and/or if dependent has a different last name than the contract holder.)

Change Type: (A=Add, C=Change, T=Termination)	***First Name***	***M.I.***	***Last Name***	***Relationship to Contract Holder***	***Social Security #***	***Sex M/F***	***Date of Birth***	***Tobacco use? Yes/No****
Change Type						Sex		Tobacco
Change Type						Sex		Tobacco
Change Type						Sex		Tobacco
Change Type						Sex		Tobacco
Change Type						Sex		Tobacco

Does any dependent adding coverage have a permanent residence different than the Primary Contract Holder? ___No ___Yes

If yes, provide name(s) and address(es):_____

_____

***Mark "Yes" for dependents age 18 or older adding coverage who have used any tobacco product** 4 times or more/week within the last 6 months.*

Section 4. Authorization

Print primary contract holder name	Date	Signature
Print spouse name (required if assuming responsibility for contract and covered dependents)	Date	Signature
Print dependent name (required if over 18)	Date	Signature
Print dependent name (required if over 18)	Date	Signature
Print broker/ agent name NPN	Date	Signature
Print manager name	Date	Signature

You must supply authorized supporting documentation to prove eligibility for your Special Election Period.

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Nondiscrimination Notice

Health First Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health First Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health First Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, accessible electronic formats)
- 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, please contact Doris Garcia-Durand .

If you believe that Health First Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Doris Garcia-Durand , ADA/Section 504 Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, doris.garciadurand@health-first.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance Doris Garcia-Durand , ADA/Section 504 Coordinator is available to help you.

You can also file a civil rights complaint 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 *https://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, 1-800-868-1019, 800-537-7697 (TDD).

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

Health First Health Plans is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

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English:
If you, or someone you're helping, has questions about Health First Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-443-4735.

Spanish:
En caso que usted, o alguien a quien usted ayude, tenga cualquier duda o pregunta acerca de Health First Health Plans, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-443-4735.

Haitian Creole:
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Health First Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 855-443-4735.

Vietnamese:
Nếu Quý vị, hay người mà Quý vị đang giúp đỡ, có câu hỏi về Health First Health Plans thì Quý vị có quyền được trợ giúp và được biết thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, xin gọi số 855-443-4735.

Portuguese:
Você ou alguém que você estiver ajudando tem o direito de tirar dúvidas e obter informações sobre os Health First Health Plans no seu idioma e sem custos. Para falar com um tradutor, ligue para 855-443-4735.

Chinese:
如果您，或是您正在協助的對象，有與 Health First Health Plans
相關的問題，您有權以您的母語免費取得幫助和資訊。請致電 855-443-4735 與翻譯員洽談。

French:
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Health First Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-443-4735.

Tagalog:
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Health First Health Plans, may karapatan ka na humingi ng tulong at impormasyon sa iyong wika nang libre. Upang makausap ang isang tagasalin, tumawag sa 855-443-4735.

Russian:
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health First Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-443-4735.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Health First Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بالرقم 855-443-4735.

Italian:
Se lei o qualcuno che sta aiutando avete domande su Health First Health Plans, ha il diritto di ottenere aiuto e informazioni nella sua lingua gratuitamente. Per parlare con un interprete, può chiamare il numero 855-443-4735.

German:
Falls Sie oder jemand, dem Sie helfen, Fragen zum Health First Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-443-4735 an.

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health First Health Plans에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-443-4735로 전화하십시오.

Polish:
Jeśli Ty lub osoba, której pomagasz, macie pytania na temat Health First Health Plans, macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Aby porozmawiać z tłumaczem, prosimy zadzwonić pod numer 855-443-4735.

Gujarati:
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમાંથી કોઇને હેલ્થ ફર્સ્ટ હેલ્થ પ્લાન્સ વિશે પ્રશ્નો હોય તો તમને તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 855-443-4735 પર કોલ કરો.

Thai:
หากคุณหรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Health First Health Plans
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับล่าม โปรดโทร 855-443-4735.