

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 (SEP) event. Please check one:
 Loss of other coverage Marriage
 Denial of Medicaid or CHIP Newborn
 Other _____
Date of SEP event: _____
Effective date of coverage: _____

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

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 (must be the last day of the month):

*** The requested termination date can be a future date, but it cannot be earlier than the date we receive this completed form.**

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:			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*

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 remaining covered dependents)	Date	Signature
Print dependent name	Date	Signature
Print dependent name	Date	Signature
Print broker/ agent name	NPN	Date
		Signature



Health Plans

Underwritten by  Commercial Plans

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 Our Civil Rights Coordinator.

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: Civil Rights Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, civilrightscordinator@hf.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Civil Rights 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.

Health Plans

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English:

This Notice has Important Information. This notice has important information about your application or coverage through Health First Health Plans. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 855-443-4735.

Spanish:

Este Aviso contiene información importante. Este aviso contiene información importante acerca de la solicitud o cobertura que usted tiene con Health First Health Plans. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 855-443-4735.

Haitian Creole:

Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a gen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Health First Health Plans. Chèche dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 855-443-4735.

Vietnamese:

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc hợp đồng bảo hiểm qua chương trình Health First Health Plans của Quý vị. Xin xem các ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 855-443-4735.

Portuguese:

Este aviso contém informações importantes. Este aviso contém informações importantes a respeito da sua solicitação ou cobertura por meio dos Health First Health Plans. Consulte datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter a sua cobertura de plano de saúde ou ajuda com custos. Você tem o direito de obter estas informações e ajuda no seu idioma e sem custos. Ligue para 855-443-4735.

Chinese:

本通知包含重要的資訊。本通知包含關於您透過 Health First Health Plans 提交的申請或保險的重要資訊。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權以您的母語免費取得本資訊及幫助。請撥電話 855-443-4735。

French:

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire Health First Health Plans. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 855-443-4735.

Tagalog:

Ang Paunawa na ito ay naglalaman ng Mahalagang Impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagkakasaklaw sa Health First Health Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan kang magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagkakasaklaw sa kalusugan o makatulong sa mga gastusin. May karapatan kang makuha ang impormasyon at tulong na ito sa iyong wika nang libre. Tumawag sa 855-443-4735.

Russian:

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Health First Health Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 855-443-4735.

Arabic:

يحتوي هذا الإشعار معلومات هامة. يحوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Health First Health Plans. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التغطية الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على معلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بالرقم 855-443-4735

Italian:

Questo avviso contiene informazioni importanti. Questo avviso contiene informazioni importanti sulla sua domanda o copertura attraverso Health First Health Plans. Cerchi le date chiave in questo avviso. Potrebbe essere necessario un suo intervento entro una scadenza determinata per consentirle di mantenere la sua copertura o sovvenzione. Ha il diritto di ottenere queste informazioni e assistenza nella sua lingua gratuitamente. Chiami il numero 855-443-4735.

German:

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Health First Health Plans. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Anspruch auf Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 855-443-4735.

Korean:

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Health First Health Plans를 통한 보장에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 확인하십시오. 귀하는 건강 보장을 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 855-443-4735로 전화하십시오.

Polish:

Niniejsze ogłoszenie zawiera ważne informacje. Niniejsze ogłoszenie zawiera ważne informacje dotyczące Państwa wniosku lub zakresu świadczeń realizowanych poprzez Health First Health Plans. Może zaistnieć potrzeba podjęcia przez Państwa pewnych działań w określonym terminie w celu zachowania ubezpieczenia zdrowotnego lub otrzymania pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Prosimy zadzwonić pod numer 855-443-4735.

Gujarati:

આ સૂચનામાં અગત્યની માહિતી છે. આ સૂચનામાં હેલ્થ ફર્સ્ટ કમર્શિયલ પ્લાન્સ દ્વારા તમારી અરજી અથવા કવરેજ વિશેની અગત્યની માહિતી છે. આ સૂચનામાંની ખાસ તારીખો જુઓ. તમારા આરોગ્ય કવરેજને જાળવી રાખવા અથવા ખર્ચ અંગે મદદ મેળવવા માટે ચોક્કસ સમયમર્યાદા સુધીમાં તમારે કાર્યવાહી કરવાની જરૂર પડી શકે છે. તમને આ માહિતી અને મદદ તમારી ભાષામાં વિના મૂલ્યે મેળવવાનો અધિકાર છે. 855-443-4735 પર કોલ કરો.

Thai:

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอขบเขตการประกันสุขภาพของคุณผ่าน Health First Health Plans โปรดดูกำหนดการสำคัญในประกาศนี้

คุณอาจจะต้องดำเนินการภายในเวลาที่กำหนดเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 855-443-4735.