Health First Health Plans
Underwritten by Health First Commercial Plans

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 SEP.

___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

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