

# 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:				
<input type="checkbox"/> <b>Change Address</b>	New Address: Street:		City:	State:	Zip:	New Home Phone #:				
<input type="checkbox"/> <b>Change Name</b>	Old Name:			New Name:						
<input type="checkbox"/> <b>Add Dependent</b>	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:
<input type="checkbox"/> <b>Delete Dependent</b>										
<input type="checkbox"/> <b>Change Primary Care Physician</b>										
Reason for addition or deletion, if not open enrollment: _____ Birth Date: _____ Adoption <input type="checkbox"/> Adoption Date: _____ Marriage <input type="checkbox"/> Marriage Date: _____ Divorce <input type="checkbox"/> Divorce Date: _____ Other: _____ Date: _____										
<input type="checkbox"/> <b>Indicate Subscriber/Dependent Who Has Other Coverage:</b>	Is your spouse employed? If yes, list employer's name and address: _____ YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, list spouse's business phone: _____									
	Are your dependents covered by other health insurance?: YES <input type="checkbox"/> NO <input type="checkbox"/> 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: _____				
<input type="checkbox"/> <b>Terminate Contract (Subscriber &amp; Dependents)</b>	Term Code*: _____ (Required - See term codes in box at right)									
<input type="checkbox"/> <b>Reinstate Contract (Subscriber &amp; Dependents)</b>	Reason for Reinstatement: _____									
<input type="checkbox"/> <b>Transfer Contract (Subscriber &amp; Dependents)</b>	From: Group Number _____ To: Group Number _____ From: Sub Group #: _____ To: Sub Group # _____ From Plan #: _____ To Plan # _____ Effective Date _____									
<input type="checkbox"/> <b>Other</b>										
<input type="checkbox"/> <b>Subscriber's Signature</b>	Signature:					Date:				
<b>* EMPLOYER INFORMATION</b>	<b>Effective Date of Change/Cancel:</b> MO DAY YR		<b>Group #:</b>	<b>Subgroup:</b>	<b>Plan Code:</b>	<b>Employer Name:</b>		<b>Employer Signature:</b>		<b>Date:</b>

**\*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