# 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: |
|---|---|---|---|---|
| ❑ Change Address | New Address: Street: City: State: Zip: | | | New Home Phone #: |
| ❑ 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: ❑ Birth Birth Date: ____/____/ ❑ Adoption Adoption Date: ____/____/
Marriage ❑ Marriage Date: ____/____/ Divorce ❑ Divorce Date: ____/____/ ❑ Other: ______ 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)

**❑ Reinstate Contract** (Subscriber & Dependents)

Reason for Reinstatement:

**❑ Transfer Contract** (Subscriber & Dependents)

From: Group Number__________ To: Group Number__________
From: Sub Group #: __________ To: Sub Group # __________
From Plan #:________To Plan # ________ Effective Date __________

**❑ Other**

**❑ Subscriber's Signature**

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

| EMPLOYER INFORMATION | **Effective Date of Change/Cancel:** MO / DAY / YR | **Group #:** | **Subgroup:** | **Plan Code:** | **Employer Name:** | **Employer Signature:** | **Date:** |
|---|---|---|---|---|---|---|---|
| | | | | | | | |



Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944