AdventHealth Advantage 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<br>__ __ __ – __ __ – __ __ __ __ | 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):<br>____ ____ / ____ ____ / ____ ____ ____ ____ | Sex:<br>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**** |
|---|---|---|---|---|---|---|---|---|
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**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 |