

## 2020 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 (<u>Healthcare.gov</u> or 1.800.318.2596).

Underwritten by Health First Commercial Plans

Section 1. Type of Transaction (Check all that apply)															
Change name/address/phone							Te	Terminate coverage							
Add dependent(s)—Adding a dependent outside of Open								For contract holder and all covered dependents							
Enrollment Period requires a Special Enrollment Period (SEP)								Only for those dependents listed in Section 3							
event. Please check one:							_	Contract holder only (spouse/dependents remain)							
Loss of other coverageMarriage							Reason:								
Denial of Medicaid or CHIPNewborn							Voluntary cancellation (Reason:) Moved from service areaDeceased								
Other															
Date of SEP event:							Other qualifying event:								
Effective date of coverage:							Date for coverage to end:								
Section 2 Prin	nary Contract	Holde	r Info	ormation											
Section 2. Primary Contract Holder Info Contract Holder SSN Member ID:				First Name					M.I.	Last Name	0.				
		Member ID.			r list Name.				101.1.	Lust Humo.					
					Apt. #:		City					State: ZIP:			
nome Address.					лµι. #.		City:					Sidle.	λισ. ΔΙΓ.		
Mailing Address (if different than above):						Apt. #: 0		City:				State:	ZIP:		
maning Address (ir dinerent than above):							City	ity.				Jaie.	μ. <b>Δ</b> Γ.		
Phone #: Cel			ell Phone #:					Email Address:							
Date of Birth (mm/dd/	Sex:			Plan Nar		Name <sup>.</sup>		Occupation:			Language:				
			Male Fem					occupation.			Languago.				
Section 3. Add	/ Change / Ter	rmina	tion I	nformati	on										
(Must attach copy o						/or if c	depend	ent has a differe	ent last na	me than th	ie con	tract hc	older.)		
Change Type:								alatianakin ta Casial		Sex		Date of		Tobacco	
(A=Add, C=Change, First Name		М.І.		Last Name				Relationship to Contract Holder			l/F	Birt		use?	
T=Termination)	iermination)								-					Yes/No*	
Does any dependent adding coverage have a permanent residence different than the Primary Contract Holder?NoYes															
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. Aut	horization														
Print primary contract holder name							Date			Signature					
							-	Duito		- Granala - G					
Print spouse name (required if assuming							D	ate	Signature						
responsibility for contract and covered dependents)															
Print dependent name							D	Date Signature							
(required if over 18)								Data							
Print dependent name (required if over 18)							D	Date Signature							
Print broker/ NPN							D	ate		Signature					
agent name								-		3					
Print manager name							D	Date Signature							

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

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