Health Net®

Group Change/Cancellation Form

Please complete applicable sections, including your signature. Use blue or black ink only.

Check box if applicable and complete corresponding section

Subscriber's last name:	First name:	M.I.:	Social Security #:	Health Net ID #:

☐ **Change address**

New address: Street	City:	State:	ZIP code:	New home phone #:

☐ **Change name**

Old name:	New name:

☐ **Add dependent** ☐ **Delete dependent** ☐ **Change primary care physician**

Term code*	Relationship to you	Last name First name M.I.	Social Security #	Gender M	Gender F	Date of birth: Mo Day Yr	Name of primary care physician	Provider ID:
				☐	☐	/ /		
				☐	☐	/ /		
				☐	☐	/ /		

Reason for addition or deletion, if not open enrollment: **Birth** ☐ **Birth date:** _____/_____/ **Adoption** ☐ **Adoption date:** _____/_____/
Marriage ☐ **Marriage date:** _____/_____/ **Divorce** ☐ **Divorce date:** _____/_____/ **Other:** Incorrectly Remove **Date:** _____/_____/

☐ **Indicate subscriber/dependent who has other coverage**

Is your spouse employed? ☐ Yes ☐ No	If "Yes," list employer's name and address: Sun Van 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:

(continued)

☑ **Terminate coverage (subscriber and dependents)**

Term code*: _____

(Required – See term codes at right)

☑ Medical ☐ Dental

☐ Vision ☐ Life

☐ **Transfer coverage (subscriber and dependents)**

From group number: _____ To group number: _____

From sub group #: _____ To sub group #: _____

From plan #: _____ To plan #: _____

Reason for plan code change: _____

Effective 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

☐ **Subscriber's signature**

Signature:	Date:

Employer completes this section

Effective date of change/cancel:	Group #:	Plan code:	Company name:	Employer signature:	Date:	Employer phone #:

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