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? YES ❑ NO ❑
If yes, list employer's name and address: ______________________________
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:

FAX: 1-818-676-8822 **MAIL**: Health Net, One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944

In Arizona, benefits are insured and/or administered by Health Net of Arizona, Inc. for HMO plans and Health Net Life Insurance Company for indemnity plans and life insurance coverage. The Health Net of Arizona, Inc. service area includes all Arizona counties. Participating Providers are neither agents nor employees of Health Net of Arizona, but are independently contracted entities that are legally responsible for their own care, treatment, and other services provided to Health Net members.

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