CHANGE/CANCELLATION FORM

Please complete applicable sections, including your signature.
Use blue or black ink only, and be sure all copies are legible.

Health Net®

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 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: