ELEVATE WELLNESS *Live Well*

CHANGE/TERMINATION FORM

Please print neatly using black or blue ballpoint pen

ALL DATES MUST BE: MM/DD/YYYY

A. Employer/Employee Information (To be completed by the employer)

Group ID Number:	Group Name:
Employee Insurance ID Number:	Employer Signature X / Date / /
Employee Name:	

B. Transaction

Transaction	Effective Date	Required Information
☐ **Termination**	/ /	**Who:** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) **Reason:** ☐ Left Employer ☐ Switched Plans ☐ Other:
☐ **Change**	/ /	**Who:** Last Name: First Name: Effective Date: / / Date of Birth: / / Other: SS#: Middle Intial: Gender: ☐ M ☐ F
		*A **New Member Enrollment Form** is required for: Loss of Dependent Status, Divorce/Separation, or Death of Subscriber.
☐ **Transfer** Complete entire section	/ /	New Plan: Reason: Actively Working: ☐ Yes ☐ No
☐ **Addition** Complete WHO, REASON and SECTION C below	/ /	**Who:** ☐ Spouse ☐ Civil Union ☐ Domestic Partner ☐ Dependent(s) **Reason:** ☐ Open Enrollment ☐ Loss of Coverage ☐ Birth/Adoption ☐ Other: ☐ Date of Marriage ☐ Date of Civil Union ☐ Date of Partnership

C. Additional Information

	Spouse	Dependent	Dependent
Social Security Number:			
Last Name:			
First Name, Middle Initial:			
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /
Gender and Disability Status:	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient, check "Yes".)	☐ Yes	☐ Yes	☐ Yes
Check all that apply:	☐ Actively employed ☐ Not actively employed	☐ Full-time Student (Age 19 - 23)	☐ Full-time Student (Age 19 - 23)
Prior Carrier What coverage you had prior to this. Policy Number: Carrier: From Date: / / Through Date: / /		/ / / /	/ / / /

ADDRESS CHANGE:

ADDRESS:
ADDRESS:
CITY:
STATE:
ZIP:

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR INSURANCE IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES

Employee Signature X _____ Date / /