Cancellation or Change Form – EMAIL TO ADMIN@UHB1.COM OR FAX TO 855-208-1140

Employee Name _____ Social Security Number _____

Home Address _____ Apt #_____ City_____ ST _____ Zip_____

Gender ☐ Male ☐ Female Date of Birth ___/___/_____ Phone _____

What are you wanting to do? _____**CHANGE** MY CURRENT PLAN _____**CANCEL** MY CURRENT PLAN

What plan are you currently on?

Limited Benefit Plan:

_____Employee Only _____Employee + 1 _____Employee + Family

Minimum Essential Coverage Plan:

_____Employee Only _____Employee + 1 _____Employee + 2 _____Employee + 3 or More

Minimum Value Plan:

_____Employee Only _____Employee + Spouse _____Employee + Child(ren) _____Employee + Family

IF YOU ARE CANCELLING, YOU MUST INITIAL IN THE WAIVER SELECTION BELOW AND SELECT A REASON WHY. **CANCELLATIONS MUST BE RECEIVED BY THE 25TH OF EACH MONTH AND WILL NOT BE CANCELLED UNTIL THE BEGINNING OF THE NEXT MONTH.

IF YOU ARE CHANGING YOUR PLAN, YOU MUST SELECT A NEW PLAN BELOW AND IF YOU ARE ADDING DEPENDENTS, YOU MUST COMPLETE THE DEPENDENT INFORMATION BELOW **CHANGES MUST BE RECEIVED BY THE 25TH OF EACH MONTH AND WILL NOT BE CHANGED UNTIL THE BEGINNING OF THE NEXT MONTH.

New Plan Selection

Limited Benefit Plan:

_____Employee Only _____Employee + 1 _____Employee + Family

Minimum Essential Coverage Plan:

_____Employee Only _____Employee + 1 _____Employee + 2 _____Employee + 3 or More

Minimum Value Plan:

_____Employee Only _____Employee + Spouse _____Employee + Child(ren) _____Employee + Family

DEPENDENT INFORMATION (If you need more room for dependents, please use another application to complete)

Dependent Information (Attach additional dependents to form.)	Date of Birth	Gender (M/F)	Relationship	Social Security No.
			Spouse	

EMPLOYEE CANCELLATION / WAIVER OF ALL BENEFITS (MUST INITIAL IF DECLINING)

_____WAIVER: I certify that I have been given the opportunity to apply for group health insurance **(Minimum Essential Coverage and a Minimum Value Plan)** and would like to cancel my benefits, as indicated, on behalf of myself, my spouse and/or my dependent child(ren). I understand that by signing this waiver, I, my spouse and/or my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the insurer(s) into waiving or declining the group health insurance. **PLEASE SELECT YOUR REASON FOR CANCELLING ALL QUALIFIED COVERAGE BEING OFFERED BY YOUR EMPLOYER:**

_____ I Already Have Qualified Coverage _____ I Already Have Medicaid _____ I Do Not Want Any Coverage At This Time
_____ I Already Have Non Qualified Coverage _____ I Receive A Health Care Subsidy _____ Financial Reasons

All cancellation or change forms must be received by the 25th of each month and changes will be made starting at the beginning of next month.

If choosing a new plan, you authorize the associated payroll deduction according to the plan you choose as described in the Notice To Applicants.

_____ _____

Employee Signature **Date**