WellAway

Keeping You Well, While You're Away.®

Policy Change Form

This Policy Change Request form should be completed and signed by the Policyholder when requesting one or more of the following changes described below. Please complete the sections applicable to your requested change(s).

Section A: Terminate Coverage

Section B: Add/Remove Dependents

Section C: Add/Remove Dental/Vision Benefits

Section D: Add/Remove Maternity Coverage

Please submit the completed form and all related correspondence to:

Enrollment@wellaway.com
Questions? Call us at +1 441-296-0651

Contact Information *Required*

Policyholder:	Date:
Requested Date of Change:	Policy Number:
Effective Date of Policy:	Broker (If Applicable):
Product/Plan:	Email:

A. Terminate Coverage

	Please Specify with a Check Mark the Reason for Termination	Required Documents & Effective Dates
	You relocated outside the United States and you are no longer permanently domiciled in the United States. Please contact a ConciergeCare counselor for more information on our other products.	• Documentation supporting early termination of policy • Effective date will be the first day of the following month
	You no longer meet the eligibility criteria of your policy.	• Documentation supporting early termination of policy • Effective date will be the first day of the following month
	You wish to terminate your policy. Request for termination is subject to the terms and conditions of your policy.	• Reason For Termination

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B. Add/Remove Dependent(s)

Special Enrollment Periods

As determined by your policy, a Special Enrollment Period is the 30-day period of time immediately following one of the special events described below, during which you may apply for coverage. If you apply for coverage during a Special Enrollment Period, the effective date of your new coverage will depend on what type of special event occurred as explained below. To apply for coverage, you must complete the Application Form for the applicable plan and submit the completed Application Form within the 30-day period. Please provide the date and proof of the special event.

(Please check the applicable box and complete the dependent information in the space provided).

	Please Specify with a Check Mark the Reason for Termination	Required Documents & Effective Dates
	You gain a dependent or become a dependent through marriage or a dependent child relocates to your covered destination.	• Passport, Driving License or official Electoral voting ID • Marriage certificate • Effective date will be the first day of the following month
	You gain a dependent or become a dependent through birth, adoption or placement for adoption.	• For newborn babies, please provide the birth certificate (Effective date will be date of birth) • For adoption or placement, please provide the court appointed document and final adoption documents. (Effective date will be the date, adopted child is placed in the residence)
	You would like to remove a dependent.	• Reason

(Please complete the dependent information in the space provided).

Name (First, Last, MI)	Sex (M/F)	Relationship	Social Security Number (SSN)	Date of Birth / Adoption (mm/dd/yyyy)	Date of Marriage (mm/dd/yyyy)	Add	Remove

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C. Add/Remove Dental/Vision Benefits

Eligibility is determined by your current policy. Please contact a ConciergeCare counselor for information regarding the applicable eligibility criteria. Optional Dental or Dental and Vision benefits cannot be purchased on a stand-alone basis. Optional benefits are only available upon the payment of the additional premium.

Dental Cover Only

Not available as a Stand-Alone Plan (Additional Monthly Rates)

Add	Member Name:	Requested Effective Date (mm/dd/yyyy)
	I wish to terminate my Dental coverage as of the renewal date. (If you opt to terminate this optional benefit ALL members will terminate)	

Dental Cover Only

Not available as a Stand-Alone Plan (Additional Monthly Rates)

Add	Member Name:	Requested Effective Date (mm/dd/yyyy)
	I wish to terminate my Dental and Vision coverage as of the renewal date (If you opt to terminate this optional benefit ALL members will terminate)	

D. Add/Remove Maternity Coverage (OneWorld or ORBE only)

WellAway provides a Maternity Global Period Coverage option to the Policyholder or the Policyholder's spouse who is NOT pregnant at the time of enrollment. Minimum age to qualify for this optional benefit is 18 and female spouse applicants legally married under the age of 18 may be considered (subject to prior written approval by WellAway). The optional Maternity Global Period Coverage is subject to the deductible and co-insurance stated in your Summary of Benefits.

OneWorld/ORBE Option Not Available as a Stand-Alone Option - *Subject to Waiting Period*

Add	Member Name:	Requested Effective Date (mm/dd/yyyy)
	I wish to terminate my Maternity coverage as of the renewal date.	

I confirm that I have requested the above changes to take place within my existing insurance policy as of the approved effective date and within the terms and conditions of my policy. I further understand that additional options to my existing plan or terminations to my existing plan will impact the amount of my premium. I authorize WellAway Limited to charge my credit/debit card on file for any additional premium payment.

This form MUST be completed and signed by the Policyholder.

Signature

Date