WellAway
Keeping You Well, While You're Away.®

Policy Change Form
La Vie a L'Etranger & New American

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

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 WellAway enrollment for more information on our other products.	• Documentation supporting early termination of policy (i.e., utility bill, lease, return ticket to Country of Origin, copy of new Certificate of Coverage, letter of resignation or termination from employer)
☐	You no longer meet the eligibility criteria of your policy.	• Documentation supporting early termination of policy
☐	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	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 or proof of domestic partnership.This proof can be in the form of any two of the below listed: - Joint Mortgage or Lease of residence - Joint Ownership of Motor Vehicle - Joint bank or investment account - Joint credit card or other financial responsibility - Will naming the partner as beneficiary - Assignment of durable power of attorney or healthcare proxy Or: - Affidavit of Domestic Partnership and copy of registration under applicable law state or municipality. • 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) • For surrogacy, please provide written notification to the Insurer at the time that the surrogacy agreement has been entered into (an official copy of the legal adoption document is also required).
☐	You would like to remove a dependent.	• Please state reason for removal of dependent. (Dependent child who has reached age 26 will automatically be terminated from policy)

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

Name (First, Last, MI)	Sex (M/F)	Relationship	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 WellAway enrollment for information regarding the applicable eligibility criteria. Optional Dental and Vision benefits cannot be purchased on a stand-alone basis. Optional benefits are only available upon our approval and payment of the additional premium.

Dental and Vision Cover

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)*	

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 _______________