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 are relocating to a country outside of your purchased Zone, back to your Country of Origin, the European Union (if you are a European national) or a Restricted Area (as defined by the Policy).	• 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)

To enroll a new Dependent after the Policyholder's enrollment, the Policyholder must submit an Application Form. The Dependent is subject to the eligibility requirements set forth below, and medical underwriting, at our discretion. We may require the completion of a medical health questionnaire whereby we may apply certain limitations or exclusions of coverage. The effective date of coverage for the new Dependent will be the date that the Insurer accepts the Application Form (or the date below, as applicable) and the required Premiums are received by the Insurer. The new Dependent will be enrolled under the same coverage as the primary Insured Person and coverage will be based upon the terms and conditions of the Policy.

Addition of a Newborn Baby (not born within the Policy)
Newborn babies may be covered, without qualifying periods, upon the Insurer's receipt of a Certificate of Birth, if at least one parent is covered by this Policy prior to the newborn's birth. If the newborn is approved for coverage by the Insurer, the effective date of the newborn's coverage:
(i) will be subject to a 30-day Waiting Period if the Certificate of Birth is received by us within 30 days of the newborn's date of birth; or
(ii) will be subject to a Waiting Period greater than 30 days if we receive the Certificate of Birth and a Certificate of Wellness from the newborn's pediatrician more than 30 days after the newborn's date of birth.

Addition of a Legally Adopted Child or Surrogacy Child
Adopted and surrogacy children may be covered, subject to the following conditions:
- The child must be less than 19 years old;
- The Policyholder must provide written Notification to the Insurer at the time that the surrogacy or adoption agreement has been entered into (an official copy of the legal adoption document is required);
- Child(ren) will be subject to underwriting review; and
- will be subject to a 30-day Waiting Period.

(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)*	

D. Add/Remove Maternity Coverage

WellAway provides a Maternity Care and Birth Benefits 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 benefit is subject to the deductible co-insurance stated in your Summary of Benefits.

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

Add	Policyholder 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 ______________