WELLFLEET
WORKPLACE

PORTABILITY REQUEST FORM

Submitting your form
Submit your form the way you like. Mail, email or fax it to:

Wellfleet Insurance Company
P.O. Box 15769
Springfield, MA 01115
Fax: 413-452-5486
Email: customercare@wellfleetinsurance.com

Helpful reminders

- This form must be received within 60 days of your cancellation of coverage under your group's policy.
- Please complete all sections of this form by typing on a computer or printing and filling in with ballpoint pen.

Questions?
If you have any questions, please contact our **Customer Care Team** at:

- workplaceclaims@wellfleetinsurance.com
- 1-855-664-5838, 8:30 a.m. - 5:00 p.m. EST

CERTIFICATE HOLDER INFORMATION

Date of request: _____ Name of employer: _____

Employment termination date (MM/DD/YY): _____

Policy certificate number:_____ Insured's SSN: _____

First Name: _____ MI: _____ Last Name: _____

Street address:_____

City: _____ State: _____ Zip code: _____

Phone #: _____ Email address: _____

DEPENDENT INFORMATION

Complete if dependents are insured under the group policy and you wish to continue their coverage.

First name: _____ Last name: _____
☐ Spouse ☐ Child DOB: _____ Sex: _____

First name: _____ Last name: _____
☐ Spouse ☐ Child DOB: _____ Sex: _____

First name: _____ Last name: _____

☐ Spouse ☐ Child DOB: _____ Sex: _____

First name: _____ Last name: _____
☐ Spouse ☐ Child DOB: _____ Sex: _____

COVERAGES CHOOSING TO PORT (continue)

☐ Accident ☐ Critical Illness ☐ Hospital Indemnity

PREMIUM PAYMENT INFORMATION

Frequency
How often would you like to be billed?
☐ Monthly (only available with automatic bank drafts) ☐ Quarterly ☐ Semi-annually ☐ Annually

Payment method
How would you like to pay for your coverage?
☐ Automatic bank draft*
☐ Direct bill**

*If you selected "**Automatic bank draft**", make sure to complete the attached "Automatic Withdrawal Authorization Form".
"Direct bill**" means you will receive a bill and remit payment at the frequency noted above. If you selected "Direct bill", make sure to include a check for the first payment with this application. Your rates can be found on the enclosed letter. The check amount should be based on the payment frequency you selected above multiplied by your monthly rate. For example, if you selected a quarterly payment option, you would multiply your monthly rate by three. Checks should be made out to "Bay Bridge Administrators, LLC".

CERTIFICATION

Signature: _____ Date: _____

AUTOMATIC WITHDRAWAL REQUEST AUTHORIZATION

Name on account
First Name: _____ MI: _____ Last Name: _____
SSN: _____
Street address:_____
City: _____ State: _____ Zip code: _____
Phone #: _____ Email address: _____

Banking information
Bank name: _____ Account type: ☐ Checking ☐ Savings
Routing # (9 digits): _____ Account #: _____

Voided check
Make sure to attach a voided check to this document.

AUTHORIZATION

I (we) authorize Wellfleet Insurance Company to initiate automatic withdrawals from my (our) account, as indicated above.

Authorized signature: _____ Date: _____