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: _____

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☐ Spouse ☐ Child DOB: _____ Sex: _____

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☐ 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 "Wellfleet Insurance".

## 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: _____