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:

- customercare@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 "Wellfleet Insurance".

CERTIFICATION

Signature: _____ Date: _____

Electronic Payment Authorization Agreement

Request Type:

select one
- ☐ ACH (*PREFERRED*)
- ☐ Wire

select one
- ☐ NEW Request
- ☐ CHANGE Request

☐ CANCEL Request

Business/Individual Information:

Name: _____

Physical Address: _____

Email Address: _____

Phone Number: _____

If Business, Authorized Person Completing this Form: _____

If Business is a Licensed Insurance Producer, Producer Number: _____

If Business, Tax ID: _____

Bank Information:

Name on Account: _____

Bank Name: _____

9 Digit Routing Number: _____

Account Number: _____

Account Type (select one): ☐ Business ☐ Personal | (select one): ☐ Checking ☐ Savings

If Changing Bank Information, Last 4 of Previous Account Number: _____

Certification and Authorization:

This form is for Businesses/Individuals utilizing US bank accounts. Do not fill out this form if you require an international payment.
I certify that: (1) the Business/Individual has a US bank account; (2) the information provided on this form is correct; (3) the bank account designated above is enabled for ACH transactions (as defined below) and free of any debit blocks (applicable only for ACH transactions); and (4) I am authorized to complete this form on behalf of such business (applicable only for business accounts). I understand it is my responsibility to provide ample time of notice to MedPro of any changes to the information I have provided in this form. Such notice must be sent securely to **ach@medpro.com** for processing.

I hereby instruct and authorize MedPro Group Inc. and its subsidiaries and affiliates ("MedPro") to: (1) initiate any necessary electronic credit, debit and/or adjustment transactions ("ACH transactions") to the bank account designated above in connection with my professional relationship with MedPro (applicable only for ACH transactions); and (2) validate the information I have provided in this form, which, for individuals, could include MedPro obtaining information that is considered a consumer report under the Fair Credit Reporting Act. I understand this instruction and authorization will remain in full force and effect until such time that MedPro has received written notification requesting a change or cancellation, and MedPro has had a reasonable opportunity to implement such request. I further understand that, notwithstanding this instruction and authorization, MedPro reserves the right, in its sole discretion, to cease electronic payment transactions at any time in lieu of another payment method. I agree to indemnify and hold MedPro and its employees and directors harmless from and against any loss, claim, damage or liability arising out of or resulting from any action taken by MedPro in reliance upon the information provided under this form that MedPro, in good faith, believes to be genuine. Both parties agree to comply fully with the provisions of all U.S. laws, rules, and regulations, including, but not limited to, those set for by the National Automated Clearing House Association (NACHA).

Printed Name: _____

Signature: _____ Date: _____

This form must be completed in its entirety. An incomplete form may not be accepted and will cause processing delays.