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Well Sense Health Plan Revocation of Personal Representative Form

Please Note: This form is used to revoke the individual listed below as your Personal Representative. By doing so, the individual will no longer be able to act on your behalf in regards to your health care coverage provided by Well Sense Health Plan. All fields are required. Incomplete or incorrect forms will be returned.

Member Information (Please print information clearly)

YOUR MEMBER ID NUMBER (FOUND ON YOUR WELL SENSE HEALTH PLAN ID CARD)			
MEMBER'S LAST NAME			
FIRST NAME	MIDDLE INITIAL		
ADDRESS	CITY	STATE	ZIP CODE
PHONE			

Personal Representative Information

I hereby revoke the following individual as my Personal Representative.

PERSONAL REPRESETATIVE NAME	DATE OF BIRTH
RELATIONSHIP TO MEMBER	

I understand that my revocation of my designation of my Personal Representative will be effective upon receipt and processing of my written revocation and that the revocation will not be valid where Well Sense Health Plan has already acted in reliance upon my designation.

Member's Signature Date

WELL SENSE HEALTH PLAN USE ONLY

REQUEST RECEIVED BY:	DATE (MM/DD/YYYY)

Mail or Fax completed form to:

Well Sense Health Plan
Attention: Member Services Dept.
1155 Elm Street, Suite 600
Manchester, NH 03101

Fax: 617-897-0884