Date: [Insert Date]

Subject: Questionnaire for Coverage Adjustment Following Geographic Relocation

Dear [Policyholder Name],

Congratulations on your recent move. Because geographic relocation is considered a qualifying life event, you may be eligible to adjust your current benefit coverage to better suit your new location.

To process these updates, please complete and return this questionnaire within [Number] days of receipt.

**Section 1: Relocation Details**

New Primary Address: [Insert Full Address]
Effective Date of Move: [Insert Date]
Reason for Relocation (e.g., Employment, Personal): [Insert Reason]

**Section 2: Coverage Adjustment Requests**

1. Do you wish to change your current health/benefit plan based on your new service area? (Yes/No): _____

2. Are you adding or removing any dependents from your plan as a result of this move? (Yes/No): _____
If yes, please list names: _____

3. Do you require a new primary care physician (PCP) assignment in your new zip code? (Yes/No): _____

**Section 3: Supporting Documentation**

Please attach a copy of one of the following as proof of relocation:

- Utility bill (dated within the last 30 days)
- Signed lease agreement or mortgage statement
- Driver's license update confirmation

**Section 4: Acknowledgment**

I certify that the information provided above is accurate and understand that changes will take effect on [Insert Effective Date Rule].

Signature: _____ Date: _____

Please return this form via email to [Email Address] or by mail to [Mailing Address].

Sincerely,

[Your Name/Department]
[Organization Name]