

# Enrollment Cancellation

**Effective \_\_\_\_\_, please cancel my enrollment in:**

Enter date here (must be the first of a month)

Option Code Number \_\_\_\_\_ Plan Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Member's Name \_\_\_\_\_  
*First Middle Last*

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

Medicare Number (As it appears on your Medicare Card) \_\_\_\_\_

Date \_\_\_\_\_ Enrollee's Signature \_\_\_\_\_

Important: Complete and mail this form as soon as possible to the HMO you are leaving, but no later than 30 days prior to the effective date you are requesting. Termination of coverage with this HMO will be effective on the first day of the month following the month the HMO receives this written request. You will not be able to receive coverage for medical care from your new option until after the effective date of disenrollment.

My current option is \_\_\_\_\_,  
and I want to change my option to \_\_\_\_\_.

No action is required if you wish to keep your current health insurance.

**USE THIS FORM FOR OPTION CHANGE ONLY**