NYSHIP New York State Health Insurance Program

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_____

Please provide the following required information for each enrolled dependent.
(Attach an additional 8½" x 11" sheet of paper, if necessary.)

Dependent's Name _____

Dependent's Social Security Number _____

Dependent's Medicare Number (if applicable) _____

Dependent's Signature _____

Dependent's Name _____

Dependent's Social Security Number _____

Dependent's Medicare Number (if applicable) _____

Dependent's Signature _____

Important: Complete and mail this form to the HMO you are leaving as early as possible prior to the effective date you are requesting. Termination of coverage with this HMO must be coordinated with your new option. 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