

TERMINATION FORM

Individual and Family Plans

Termination

Subscribers may use this form to request termination of their coverage. For new enrollment or change requests, please use the Individual and Family Plan Application/Enrollment/Change Form.

Termination Effective Dates

A member is no longer covered as of the termination effective date. For example, if the termination date is Jan 1, 2020, the last minute of coverage was on Dec 31, 2019, 11:59 p.m. Coverage for dependents ends when the subscriber's coverage terminates. Terminated subscribers and dependents are responsible for any medical services received after the termination date, **even if the person is hospitalized or undergoing treatment for an ongoing condition.**

For Sutter Health Plus to process your request, you must sign and return the last page of this form.

Missing information may delay processing.

Email or fax your completed form to:

Email: shpifp@sutterhealth.org

Fax: 1-916-736-5090

You must encrypt or secure any documents sent by email. If you cannot encrypt or secure emails, please fax all documents and keep a copy for your files.

Need Assistance?

If you have questions about completing this form, please contact Sutter Health Plus Member Services at 1-855-315-5800 (TTY: 1-855-830-3500), Monday through Friday from 8 a.m. to 7 p.m. Sutter Health Plus provides translation services and other language assistance services to you free of charge.

Subscriber/Dependent First and Last Name	Date of Birth	Termination Effective Date	Member Identification Number

Subscriber/Financially Responsible Party Signature

Date