TERMINATION FORM

Health Care Coverage Application / Enrollment / Change Form

Termination

- Only authorized employer representatives may request terminations
- Please complete all fields

Termination Effective Dates

When a member is no longer eligible for coverage, the coverage termination date is the first day a member is not covered (e.g., if the termination date is Jan 1, 2018, the last minute of coverage was on Dec 31, 2017, 11:59 p.m.). Coverage for dependents ends when the subscriber's coverage terminates. Terminated subscribers and members are responsible for any medical services received after the termination date, **even if the person is hospitalized or undergoing treatment for an ongoing condition.**

Notice of Termination

The group is required to inform the subscriber in advance of the date the membership will terminate. Please refer to the *Evidence of Coverage and Disclosure Form* for more information.

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

Fax or email your completed form to:

Fax: 1-916-736-5426

Email: *shpenrollmentmailbox@sutterhealth.org*

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.

Employers should only use this form to terminate subscribers or members. If you have a new enrollment or change, please use the Employee Enrollment/Change Form.

Sutter Health Plus
Your Health Plan

Termination Form

Group Name

Group Number

Termination Reason Codes

1. Involuntary Termination
2. Voluntary Termination
3. Divorced
4. No Longer Lives/Works In Service Area
5. Retired
6. Deceased
7. Reduction of Hours
8. Exhausted Federal COBRA
9. Leave of Absence
10. Enrolled in Error
11. Loss of Disabled Status
12. Other

Member/Subscriber First and Last Name	Date of Birth	Termination Effective Date	Termination Reason Code

Employer/Authorized Representative Signature

Date