

**Tufts Health Plan  
Disenrollment Request Form**

If you request disenrollment, you will continue to receive all medical care from Tufts Health Plan until the effective date of disenrollment

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Tufts Health Plan Identification # \_\_\_\_\_

Your Signature: \_\_\_\_\_ Term Date: \_\_\_\_\_

