Request for Plan Termination
Medicare Group Plans

Please print in ink:

Name of Organization: City of Worcester **Group #:** ____________________

Name of Current Plan: Fallon Senior Plan HMO

Member's Last Name: ____________________, **First Name** ____________________ **MI** ______

Address: ____________________________________ **City:** __________________ **Zip:** ___________

Telephone #: (______) __________-____________ **DOB:** ___/___/_____ **Gender:** M or F

Medicare Claim #: (Health Insurance Claim Number) __________-__________-____________ _________

Termination of coverage:

Termination of health insurance coverage for this member will be effective the first day of the month following receipt of an authorized request, unless a specific date up to 3 months after the request is received. Members who have requested termination of coverage must continue to receive all medical care as provided in their Member Handbook/Evidence of Coverage until the effective date for plan termination. Requests for retroactive termination of coverage will be considered on a case by case basis and are subject to CMS approval.

Note to Medicare beneficiary:

If this is the first time that you had enrolled into a Medicare Advantage plan, and if you are requesting to terminate coverage within 12 months of your initial effective date of enrollment in a Medicare Advantage plan, then you may be guaranteed issuance of certain Medi-gap coverage. You may contact your state insurance department or counseling agency (1-800-882-2033 or TTY 1-800-872-0166) to get more information about the availability of Medi-gap insurance in your state.

Requested date of termination: _____/_____/_____

Termination Reason:

_____ voluntary (60)
_____ deceased (66) DOD _____/_____/_____
_____ nonpayment (92)
_____ moved out of area (52)
_____ request by group (81)

X ____ _____/_____/_____

Signature of member or signature of authorized representative date

An authorized representative signing on behalf of a member must provide the following information. If not the group benefits administrator, an authorized representative form signed by the member prior to this request must be included with this request

______________________________ ______________________________
Print full name relationship to member

______________________________ ______________________________
Address telephone number

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