



# Request for Plan Termination (Medicare Group Plans)

Please print in ink.

<b>Name of organization:</b>		
<b>Group number:</b>		
<b>Current plan (circle one):</b> Fallon Senior Plan Premier HMO / Fallon Senior Plan Premier Preferred PPO / Fallon Companion Care		
<b>Member's last name:</b>	<b>First name:</b>	<b>MI:</b>
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>ZIP:</b>
<b>Telephone:</b> (     )	<b>Date of Birth:</b> ___/___/_____	<b>Gender:</b> M or F
<b>Medicare claim number:</b> (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 *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 Medicare's approval. The member is responsible to contact the employer group benefits office in advance of the termination date.

**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 Medigap 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 Medigap insurance in your state.

**Requested date of termination:** \_\_\_/\_\_\_/\_\_\_\_\_

**Termination reason:**

- |  |  |
|--|--|
| <input type="checkbox"/> Voluntary                   | <input type="checkbox"/> Moved out of area |
| <input type="checkbox"/> Deceased DOD: ___/___/_____ | <input type="checkbox"/> Request by group  |
| <input type="checkbox"/> Non-payment                 |  |

X \_\_\_\_\_  \_\_\_/\_\_\_/\_\_\_\_\_

**Signature of member or authorized representative** **Date**

*An authorized representative signing on behalf of a member must provide the information below. 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**