



POLICY TERMINATION FORM

Per the terms in your policy you may terminate Coverage for yourself and any Enrolled Dependents for any reason **with advance written notice.**

You may use this form to make your request. An incomplete form may delay the processing of your request.

Member Name: _____

Member Address: _____

Member Identification Number: _____

Member Phone Number: _____

Requested Cancellation Date: _____

Subscriber's Termination Request

Entire Policy Subscriber only (if Policy includes Dependents)** Dependent(s) Only (list below)

**** If Subscriber only termination, a new enrollment application is required to maintain dependent coverage.
Please contact our office for assistance.**

Please list the **Dependent Individuals** to be terminated from the policy. **Use additional paper if needed.**

Last Name	First Name	Middle Initial	Member ID#

Termination Reason

In order for Community Health Choice, Inc. to accurately report Health Care Statistics, please provide a reason for the termination by checking the most appropriate box.

<input type="checkbox"/>	Premium Rate	<input type="checkbox"/>	Service provided by Community	<input type="checkbox"/>	Participating Provider Network
<input type="checkbox"/>	Benefits	<input type="checkbox"/>	Moving out of Coverage Area	<input type="checkbox"/>	Eligible for Employer Coverage
<input type="checkbox"/>	New Carrier	<input type="checkbox"/>	No Coverage	<input type="checkbox"/>	Other (see Below)

Other (please explain) _____

Member Name (Print) _____ Signature: _____ Date: _____

A signature must be included for all dependents 18 and older.

This form can be returned via Email to MemberServices@CommunityCares.com, by Fax to (713) 295-2293- Attn: Fulfillment Department or by mail to Community Health Choice, Attn: Fulfillment Dept., 2636 South Loop West., Suite 125, Houston, TX 77054.

For questions please contact Member Services at (713) 295-6704 or Toll-Free at (855) 315-5386.