PRESBYTERIAN Health Plan, Inc.

Individual & Family Plan - Voluntary Termination Form

Use this form for Off Exchange Individual and Family Plan member terminations. If you have any questions please call: Presbyterian Customer Service Center at **1-855-923-7528**, Monday through Friday 7 a.m. – 6 p.m.

Do Not Use This Form if enrolled On Exchange through **BeWellnm,** contact them directly at **1-833-862-3935** to submit any changes.

RETURN INFORMATION	
By Fax: (505) 923-5888	**By Mail:** Presbyterian Health Plan, Inc. P.O. Box 27489, Albuquerque, NM 87125-7489

MEMBER INFORMATION			
Primary Policy Holder's Name**:**		Member ID#**:**	
Address**:**		Social Security Number**:**	
City/State**:**	Zip Code**:**	Phone Number**:**	Email**:**

TERMINATION REQUEST

1. ☐ Entire Policy - All members
2. ☐ Spouse and/or Dependents Only (complete dependent information in section below)
3. ☐ Subscriber Only – Spouse/Dependents will keep coverage **with**:
   - ☐ Bank or Credit Card Authorization on file
   - ☐ New Bank or Credit Card Authorization

Name (First and Last)	DOB mm/dd/yyyy	Gender Male/Female	Relationship to Subscriber	Termination Date Month/Year

REASON FOR TERMINATING POLICY

☐ Rates too high	☐ Moved to a different insurance Group plan (name):
☐ Dissatisfied with service	☐ Moved to a different insurance Individual plan (name):
☐ Dissatisfied with benefits	☐ Moved to a different Presbyterian Group, Medicaid, or Medicare plan (effective date):
☐ Moved out of service area	

I understand terminations are only effective on the last day of the month. **I understand** that if this form is received on or before the **last day of the month**, coverage will terminate at the end of the same month. **I understand** that submission of this form is not a guarantee that the premium draft will be cancelled by the 25th of the month (or following business day).

_____	**X**_____	_____
Print Name of Policy Holder or Legal Guardian	Signature **Required** of Policy Holder or Legal Guardian	Today's Date
_____	**X**_____	_____
Print Name of Spouse	Signature **Required** of Spouse	Today's Date

For information on Presbyterian Health Plan's Nondiscrimination Notice, go to https://www.phs.org/nondiscrimination.