Chinese Community Health Plan CCHP

Form B1

Employee Disenrollment Notice Fax to CCHP Sales Department (415) 955-8819

GROUP INFORMATION

Group Name	Group Number

Please TERMINATE the following member(s)
Disenrollment effective date (last day of the month): ____________________

Member(s)	Last Name	First MI	Date of Birth	Member ID#
☐ Employee				
☐ Spouse ☐ Domestic Partner				
☐ Daughter ☐ Son				
☐ Daughter ☐ Son				
☐ Daughter ☐ Son				

Please choose the appropriate disenrollment REASON below:

- ☐ D005 Employment Termination *(e.g.resign, layoff, etc.)*
- ☐ D035 Reduction in Hours
- ☐ D028 Ineligible Dependent *(turned 26 years old)*
- ☐ D034 Switched to Other Carrier During Open Enrollment
- ☐ D007 Enrollment in Spouse Group Health Insurance
- ☐ D040 Other Termination *(e.g.terminate dependent coverage)*

  ____
  Please specify

- ☐ D044 Employer Discontinued Group Health Benefit
- ☐ D032 Enrollment in Healthy San Francisco
- ☐ D009 Eligible for Medicare
- ☐ D003 Retirement
- ☐ D002 Divorced
- ☐ D001 Deceased
- ☐ D048 Disenroll/Transfer to Covered CA

☐ ***I agree that the above information is true, and I authorize CCHP to make the above changes.***

______________________ Employer/Broker Name *(Please Print Clearly)*:

______________________ Employer/ Broker Signature:

______________ Date:

CCHP USE ONLY: