

**Termination/Disenrollment Request**

Fax to CCHP Sales Department 1-415-955-8819

**GROUP INFORMATION**

Group Name	Group Number
Group Contact Name & Title	Contact Phone Number

Please **TERMINATE**     **Member(s)**     **Group**

Disenrollment effective date (**LAST DAY** of the month): \_\_\_\_\_

Member(s)	Last Name	First	MI	Date of Birth	Member ID#
<input type="checkbox"/> Employee					
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner					
<input type="checkbox"/> Daughter <input type="checkbox"/> Son					
<input type="checkbox"/> Daughter <input type="checkbox"/> Son					
<input type="checkbox"/> Daughter <input type="checkbox"/> Son					

**Please choose the appropriate disenrollment REASON below:**

<input type="checkbox"/> D005 Employment Termination (e.g. resign, layoff, etc.)	<input type="checkbox"/> D044 Employer Discontinued Group Health Insurance
<input type="checkbox"/> D035 Reduction in Hours	<input type="checkbox"/> D043 Business Closed
<input type="checkbox"/> D028 Ineligible Dependent (turned 26 years old)	<input type="checkbox"/> D009 Eligible for Medicare
<input type="checkbox"/> D034 Switched to Other Carrier During Open Enrollment	<input type="checkbox"/> D003 Retirement
<input type="checkbox"/> D007 Enrollment in Spouse Group Health Insurance	<input type="checkbox"/> D010 Eligible for Medi-Cal
<input type="checkbox"/> D040 Other Termination (e.g. terminate dependent coverage)	<input type="checkbox"/> D045 Ineligible Group Size (down to 1 EE)
_____	<input type="checkbox"/> D001 Deceased
Please specify	<input type="checkbox"/> D048 Enrolled 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:**