Balance by CCHP

Termination/Disenrollment Request Send to CCHP Secure Fax 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#
☐ 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 Insurance
☐ D043 Business Closed
☐ D009 Eligible for Medicare
☐ D003 Retirement
☐ D010 Eligibile for Medi-Cal
☐ D045 Ineligible Group Size *(down to 1 EE)*
☐ D001 Deceased
☐ 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: