fallonhealth

Request for Plan Termination (Medicare Group Plans)

Name of organization:		
Group number:		
Current plan (choose one): ☐ Fallon Medicare Plus™ Premier HMO ☐ Fallon Medicare Plus™ Central Premier HMO		
Member's last name:	**First name:**	**MI:**
Address:		
City:	**State:**	**ZIP:**
Telephone: ( )	**Date of birth:** ___/____/_____	**Gender:** ☐ M ☐ F
Medicare number:		

Termination of coverage:
Termination of health insurance coverage for this member will be effective the first day of the month following receipt of an authorized request, unless a specific date up to 3 months after the request is received. Members who have requested termination of coverage must continue to receive all medical care as provided in their *Evidence of Coverage* until the effective date for plan termination. Requests for retroactive termination of coverage will be considered on a case-by-case basis and are subject to Medicare's approval. The member is responsible for contacting the employer group benefits office in advance of the termination date.

Note to Medicare beneficiary:
If this is the first time that you had enrolled into a Medicare Advantage plan, and if you are requesting to terminate coverage within 12 months of your initial effective date of enrollment in a Medicare Advantage plan, then you may be guaranteed issuance of certain Medigap coverage. If you have any questions about Medigap insurance plans, you can contact SHINE (Serving the Health Insurance Needs of Everyone) at 1-800-243-4636 (TTY: 1-877-610-0241). You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

Requested date of termination: _____/_____/_____

Termination reason: ☐ Voluntary ☐ Moved out of area ☐ Non-payment

☐ Deceased DOD: _____/_____/_____ ☐ Request by group

over

X_____ ____/____/_____

Signature of member or authorized representative **Date**

An authorized representative signing on behalf of a member must provide the information below. If not the group benefits administrator, an Appointment of Representative Form signed by the member prior to this request must be included with this request.

_____ _____

Print full name **Relationship to member**

_____ _____

Address **Telephone number**