COMMUNITY HEALTH CHOICE
COMMUNITY CARES

POLICY TERMINATION FORM

Per the terms in your policy you may terminate Coverage for yourself and any Enrolled Dependents for any reason **with advance written notice.**

You may use this form to make your request. An incomplete form may delay the processing of your request.

Member Name: _____

Member Address: _____

Member Identification Number: _____

Member Phone Number: _____

Requested Cancellation Date: _____

Subscriber's Termination Request

☐ Entire Policy ☐ Subscriber only (if Policy includes Dependents)** ☐ Dependent(s) Only (list below)

**** If Subscriber only termination, a new enrollment application is required to maintain dependent coverage. Please contact our office for assistance.**

Please list the **Dependent Individuals** to be terminated from the policy. **Use additional paper if needed.**

Last Name	First Name	Middle Initial	Member ID#

Termination Reason

In order for Community Health Choice, Inc. to accurately report Health Care Statistics, please provide a reason for the termination by checking the most appropriate box.

	Premium Rate		Service provided by Community		Participating Provider Network
	Benefits		Moving out of Coverage Area		Eligible for Employer Coverage
	New Carrier		No Coverage		Other (see Below)

Other (please explain) _____

Member Name (Print) _____ Signature:_____ Date: _____

Member Name (Print) _____ Signature:_____ Date: _____

Member Name (Print) _____ Signature:_____ Date: _____

Member Name (Print) _____ Signature:_____ Date: _____

A signature must be included for all dependents 18 and older.

This form can be returned via Email to MemberServices@CommunityCares.com, by Fax to (713) 295-2293- Attn: Fulfillment Department or by mail to Community Health Choice, Attn: Fulfillment Dept., 2636 South Loop West., Suite 125, Houston, TX 77054.

For questions please contact Member Services at (713) 295-6704 or Toll-Free at (855) 315-5386.