Subscriber's Name:

MEDICA®

Medica Individual and Family Health Plans

POLICY TERMINATION FORM

Complete and return this form to terminate (cancel) your Medica Individual and Family Health plan policy.

Please PRINT CLEARLY in blue or black ink.

Return completed form to:
Medica
CW195IFB
PO Box 9310
Minneapolis, MN 55440-9310

Or fax it to:
952-992-2511

SECTION A MEMBER INFORMATION

Note: This section must be completed.

Subscriber

First name | Middle initial | Last name

Member ID number | Birthdate (mm/dd/yyyy)

Address

Street | City | State | ZIP

SECTION B REQUEST TO TERMINATE POLICY

Reason for termination

- ❑ Enrolled in plan offered by my employer
- ❑ Enrolled in another individual plan through another insurance carrier
- ❑ Eligible for and enrolled in a Medicare plan
- ❑ No longer an eligible dependent
- ❑ Premium is too expensive / unable to continue to afford premiums
- ❑ Dissatisfaction with coverage, explain: _____
- ❑ Death, please indicate date of death: ___ / ___ / ___
- ❑ Enrolled in a parent or spouse's plan
- ❑ Moved out of state / country
- ❑ Enrolled in another individual plan through Medica

Requested termination date

You can terminate your coverage at the end of any month (future dates only) or on the date of death.
I'm requesting my coverage terminate on: ___ / ___ / ___

Note: If you're signed up for automatic payments from your bank account (ACH), please request termination by the 20th of the month. This will prevent an ACH withdrawal for the following month.

SECTION

F AUTHORIZATION AND REPRESENTATION

TO BE SIGNED BY SUBSCRIBER

I understand and agree that signing this form will terminate my Medica policy effective the date indicated on this form.

Please provide signature below if subscriber is under age 18:

Signature of subscriber	Date
X	

Signature of parent or legal guardian	Date
X	

FOR OFFICE USE ONLY

Date received:	Policy termination date:

MEDICA PRIVACY NOTICE

Medica takes its responsibility of protecting your personal information seriously. Where possible, Medica de-identifies or encrypts personal information. We use and disclose personal information only to the extent necessary to conduct treatment, payment and health care operations, or to comply with legal, regulatory or accreditation requirements.

Medica and its business associates obtain, maintain, use and share personal information to carry out certain routine activities. Routine activities include: (i) treatment-related activities, such as referring you to a doctor or other provider; (ii) payment-related activities, such as paying a claim for medical services rendered; and (iii) health care operations, such as professional peer review.

The law also gives you rights to access, copy, and amend your personal information. You have the right to request restrictions on certain uses and disclosures of your personal information. You also have the right to obtain information about how and when your personal information has been used and disclosed.

Medica's full Privacy Notice is available upon request by calling **1-888-592-8211** (TTY: **711**) or by going to **medica.com.**

MEDICA®

Mail Route CW195IFB, PO Box 9310, Minneapolis, MN 55440-9310

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this document, call 1-800-952-3455.

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-800-952-3455.

Yog koj xav tau kev pab dawb txhais daim ntawv no, hu rau 1-800-952-3455.

如果您需要我們免費幫您翻譯此文件，請致電 1-800-952-3455。

Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-800-952-3455.

Sanadnikun kaffaltiimaleeakkaisiniifhiikamuyoobarbaadd-an 1-800-952-3455 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند فاتصل على الرقم 1-800-952-3455.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-800-952-3455.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການແປເອກະສານນີ້, ໃຫ້ໂທຫາ 1-800-952-3455.

이 문서를 번역하는 데 무료로 도움을 받고 싶으시면 1-800-952-3455로 전화하십시오.

Si vous désirez obtenir gratuitement de l'aide pour traduire ce document, appelez le 1 800 952 3455.

နမ့်လိၣ်ဘၣ်တၢ်မၤစၢၤကလီလၢတၢ်ကွဲးကျိၤထံလံာ်တီၤအံၤဒီး ကိး 1-800-952-3455.

Kung nais mo ng libreng tulong sa pagsasalin ng dokumentong ito, tumawag sa 1-800-952-3455.

ይህን ሰነድ ለመተርጎም ነጻ እርዳታ ከፈለጉ በ 1-800-952-3455 ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovog dokumenta, nazovite 1-800-952-3455.

T'áá jiik'é díí naaltsoos t'áá nizaadk'ehjí bee shí ká'adoowoł ninizingo kojį' hodíílnih, 1-800-952-3455.

Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-800-952-3455 an.

COMIFB-0119-K