

## Individual Member Voluntary Termination Form

### RETURN INFORMATION

By FAX: **(505) 923-8252**

By Mail: P.O. Box 26267, Albuquerque, NM 87125- 6267

If you have any questions, please call our Presbyterian Customer Service Center at (505) 923-6980 or toll-free at 1-800-923-6980, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users should call 1-877-298-7407.

### MEMBER INFORMATION

Primary Policy Holder's Name:		Member ID Number:		
Address:		Social Security Number:		
City/County/State:	ZIP:	Daytime Phone Number:	E-mail Address:	

### CHECK (✓) THE BOX OF YOUR CURRENT PLAN

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> PresMetro Plan | <input type="checkbox"/> Individual Care Plan | <input type="checkbox"/> Minimum Health Care Plan (K1) |
| <input type="checkbox"/> PresSolo Plan  | <input type="checkbox"/> Advantage Care Plan  | <input type="checkbox"/> Individual Conversion Plan    |

### CHECK (✓) THE BOX FOR TERMINATION REQUEST

- Your policy    or     A dependent on your policy (indicate the dependent(s) in the section below)

### LIST THE DEPENDENT YOU WISH TO TERMINATE ON YOUR POLICY

Social Security Number	Last Name	First Name	M I	DOB <small>(Mo./Day/Yr.)</small>	Gender	Age	Relationship	Effective Date <small>(Mo./Day/Yr.)</small>

### REASON FOR TERMINATING POLICY

Please indicate the reason for terminating your policy by checking (✓) the appropriate box below.

<input type="checkbox"/> Rates too high	<input type="checkbox"/> Moved to another carrier, (carrier name):
<input type="checkbox"/> Dissatisfied with service	<input type="checkbox"/> Moved to another carrier's Individual coverage (carrier name):
<input type="checkbox"/> Dissatisfied with benefits	<input type="checkbox"/> Eligible for Employer Group coverage, with <b>Presbyterian</b> (Group name):
<input type="checkbox"/> Moved out of service area	<input type="checkbox"/> Other (please describe):

Termination Dates: If notice is received on or before the 25<sup>th</sup> of the month, coverage will terminate at the end of the same month. If notice is received after the 25<sup>th</sup> of the month, coverage will terminate at the end of the following month.

\_\_\_\_\_  
Name of policy holder (please print)  
(Or Legal Guardian if Member is a minor)

x \_\_\_\_\_  
Signature of policy holder (required)  
(Or Legal Guardian if Member is a minor)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Name of policy holder spouse (please print)  
(Or Legal Guardian if Member is a minor)

x \_\_\_\_\_  
Signature of policy holder spouse (required)  
(Or Legal Guardian if Member is a minor)

\_\_\_\_\_  
Today's Date