Request for voluntary discontinuation of coverage

This form is intended for the use of Individual non-Marketplace and Senior Supplement members only.

This is to notify MercyCare Health Plans, that I am requesting termination of my coverage effective on the date listed below. I understand that all claims incurred after this date will be denied by MercyCare Health Plans and payment of any and all claims incurred by me or my dependents (if applicable) is my full responsibility.

____
Subscriber Name

____
Member Number

____
Date of Birth

____
Address

____
Phone Number

____
Subscriber Signature

____
Requested Discontinue Date

Note: If this notification is received after the requested discontinue date, an explanation for the retroactive discontinuation is necessary for review and approval.

For Enrollment Department use only:

Discontinue Date Approved: ______________________________

Approved by: ____________________________ Date: ______________________

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MercyCare Health Plans™