

Subscriber's name:

Medica Individual and Family Health Plans

POLICY TERMINATION FORM

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

Please **PRINT CLEARLY** in blue or black ink.

Return completed form to:

Medica
CW295
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 # Date of birth (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.

Continues on next page...

C 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 the Subscriber is under age 18:

Signature of Subscriber:	Date:
X	

Signature of Guarantor, Parent or Legal Guardian:	Date:
X	

D 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** or by going to **medica.com**.

MEDICA®

Mail Route CW295, PO Box 9310, Minneapolis, MN 55440-9310

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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: Lori Braegelman, Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, lori.braegelman@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, 1-800-368-1019, 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 information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov toj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的 Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей идентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທ ຫາເລກໜາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမူနာအုပ်စိုးတို့ထံစာကလိနွှံ့နာတော်တော်ကျိအံလောအကလိနွှံ့, ကိးလီဝဲဝဲနီနီဂံလောအုပ်စု ယုတ်လတ်တီလတ်မိအုပုအံမုတမုဖဲနနနီနီခေခေ လတ်ဆုတ်သးခးကုအလီခဲတကပယအဖိခိနီနီတက့ါ.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ህ ሰነድ ውስጥ ያለውን ቁጥር ወይም Medica መታወቂያ ካርድዎ ስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'è shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího' d'ilzínígi bine'déé' námboo biká'ígííjjí' béésh bee hodíilnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.

COMIFB 1016