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

_____

Subscriber Signature

_____

Member Number

_____

Requested Discontinue Date

Note: This form should be submitted within 30 days of the requested discontinue date. Submissions greater than 30 days will be processed the last day of the prior month received by MercyCare Health Plans.

Please return completed form to:
Mail: MercyCare Health Plans, PO Box 550, Janesville WI 53547-0550
Fax: (608) 752-3751
Email: mchpenrollment@mhemail.org

For Enrollment Department use only:

Discontinue Date Approved: _____

Approved by: _____ Date: _____

MercyCare Health Plans™