Termination Form

FOR INDIVIDUAL ADVANTAGE OR CAL-COBRA

Western Health Advantage

Mail to: 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833

Send it by fax to: 916.568.0334

Direct questions to: 916.563.2206 or 888.442.2206

Fill out the information below to terminate coverage with Western Health Advantage for yourself or dependent(s).

Western Health Advantage must be notified within 30 days of the termination date. If a termination date is not provided on the form, your coverage will be terminated on the last day of the month received.

Subscriber Name _____

Member Identification Number _____

Social Security Number _____

Phone Number _____

SIGNATURE _____ **Date** _____

Subscriber/Responsible Party (signing on behalf of self or Applicant under the age 18)

MEMBER INFORMATION Provide all information requested for yourself and/or dependent to be terminated from account.

Member Full Name (yourself or dependent)	**Member ID**	**Termination Date**	**Termination Reason*** (see below)

***TERMINATION REASON** Use the following number code to indicate reason for termination in the table above:

1. Change of insurance carriers
2. Enrolled in Medicare
3. Moved out of service area
4. Member deceased
5. Cal-COBRA members only: voluntary termination
6. Other (explain): _____