Individual Plans

Policy Termination Form

To terminate your policy, please complete the information below. After completing the form, please return it by:

Fax
(217) 902-9755, ATTN: Individual Enrollment

Email
IndividualEnrollment@HealthAlliance.org

Mail
Health Alliance Medical Plans
ATTN: Individual Enrollment
3310 Fields South Drive
Champaign, IL 61822

Subscriber First Name ______________________________ Subscriber Last Name ______________________________

Member Number

9									–		

☐ Term Subscriber and All Dependents
OR
☐ Term Only These Dependents:

1. First Name ______________________________ Last Name ______________________________
2. First Name ______________________________ Last Name ______________________________
3. First Name ______________________________ Last Name ______________________________
4. First Name ______________________________ Last Name ______________________________

By completing this form, I request the termination of the Health Alliance™ policy named above. I understand that Health Alliance will terminate the benefits and coverage of the named subscriber and any associated dependents (if applicable) on the last day of the month in which this form is received by Health Alliance.

Reason for termination:

☐ Enrolled in Health Alliance Employer Group Plan
☐ Enrollment in an Employer Group Plan with another carrier

Name of new carrier: ____
☐ Deceased
☐ Freedom of choice
☐ Poor customer service
☐ Public aid eligibility
☐ PCP/Specialist not in network

Name of desired PCP/specialist: ____
☐ Recently married/joined spouse's plan
☐ Too expensive
☐ VA benefits

☐ Other: ____

Please share any comments you might like to offer to help us improve.

______________________________ ______________________________ ____________________

Print Subscriber Name | Subscriber Signature | Date of Signature

☐ I agree that the typed name above shall be treated as a valid signature for all purposes of this form.