Termination Form

For Cal COBRA or Individual and Family Plans

How to use this form:

Subscribers, or brokers on their behalf, may use this form to request termination of their Cal COBRA or individual and family plan (IFP) coverage. If we receive the termination notice on or before the last day of the month, the coverage termination will be effective the first day of the following month. For additional information on coverage termination requests, please refer to your Evidence of Coverage and Disclosure Form.

Please use the Individual and Family Plan Application/Enrollment/Change Form for new enrollment or change requests.

How to submit this form:

You must email or fax your signed and completed form to Sutter Health Plan. Missing information may delay processing your request.

EMAIL
shpserviceteam@sutterhealth.org

FAX
916-736-5090

Need Assistance?

If you have questions about completing this form, please contact Sutter Health Plan Customer Service at **855-315-5800** (TTY: 855-830-3500), Monday through Friday from 8 a.m. to 7 p.m. Sutter Health Plan can provide translation services and other language assistance services to you free of charge.

Subscriber/Dependent First and Last Name	Date of Birth	Termination Effective Date	Member Identification Number	Terminate coverage for:
				☐ Cal COBRA ☐ IFP
				☐ Cal COBRA ☐ IFP
				☐ Cal COBRA ☐ IFP
				☐ Cal COBRA ☐ IFP
				☐ Cal COBRA ☐ IFP
				☐ Cal COBRA ☐ IFP

Subscriber/Financially Responsible Party/Broker Signature **Date**

Sutter Health Plan