Employer Termination Request Form

Sutter Health Plan

Employer Termination

This form is used to terminate group coverage with Sutter Health Plan. Please use the Employer Change Request Form to update contact information such as address, name or other changes.

Termination Effective Dates

You must complete and submit this form at least 30 days before the requested termination date. Coverage terminates on the first day of the month following the 30-day notice period. Sutter Health Plan does not allow mid-month terminations. When the group coverage terminates, coverage terminates for subscribers and dependents. Terminated subscribers and dependents are responsible for the cost of any medical services received after the termination date, even if the person is hospitalized or undergoing treatment for an ongoing condition.

Notice of Termination

The group is required to inform all subscribers in advance of the date the coverage will terminate. Please refer to the Evidence of Coverage and Disclosure Form for more information.

For Sutter Health Plan to process your request, you must sign and return the last page of this form. Missing information may delay processing.

Email your completed form to: **shpserviceteam@sutterhealth.org**

Section A – Group Information

Legal Company Name

DBA (Account Name) | Group ID | Requested Effective Date

Address | City | County

State | ZIP | Phone | Email

Section B – Termination Reason (Select all applicable)

- ☐ Carrier change – Please provide the name of the new carrier: _____
- ☐ Change of ownership or merger
- ☐ Company no longer in business
- ☐ Dissatisfied with customer service
- ☐ Inadequate benefits
- ☐ Limited network
- ☐ Need a PPO option
- ☐ No employees in the service area
- ☐ Not offering coverage due to financial reasons
- ☐ Noncompetitive quote
- ☐ Purchasing directly through CaliforniaChoice (small group only)
- ☐ Other: _____

Please be advised that any outstanding premiums must be paid in full immediately upon termination of your policy.

Employer/Authorized Representative Signature | Date