

Please Mail Completed Form to: Medica IB 401 Carlson Pkwy MR 555 Minnetonka, MN 55305
Or Fax Completed Form to: Medica IB at 952-992-3198

MEDICA®

Individual Policy Termination Form

Name:	Birth date: (month/day/year)
Street Address:	ID Number:
City, State, ZIP Code:	

Medica terminates coverage the end of the month in which the Termination Form is received by Medica or on the date of death.

I wish to cancel my Medica Individual Policy effective: _____

Member Signature: _____

Today's Date: _____

Or signature of legally authorized representative (Executor, attorney-in-fact, conservator, or guardian.
Proof of authorization must be attached).

If premiums are automatically withdrawn from a bank account (ACH process), please cancel this payment process by sending this form by the 20th day of the month. This will prevent an ACH withdrawal on the 5th day of following month.

REASON FOR CANCELLATION IS: (Please check one)

- Eligible for and elected coverage under an employer group policy in the market.
- Eligible for and elected coverage under an individual plan through another insurance carrier in the market.
- Eligible for and elected a Medicare supplement policy in the market.
- No longer an eligible dependent spouse or child under the plan (dissolution of marriage, dependent child reaching maximum age, enrollee became eligible for Medicare or death of the enrollee).
- Premium is too expensive / unable to continue to afford premiums.
- Dissatisfaction with coverage, explain: _____
- Date of death: _____
- Became eligible for and elected coverage under a parent or spouse's plan.
- Moved out of state/ country.
- Obtained a different Individual Policy through Medica.