univera HEALTHCARE

CONFIDENTIAL

Only One Employee Per Worksheet

Membership Cancellation Worksheet

Please print clearly. Coverage ends at 11:59 p.m. on the date you indicate. Group Administrator's signature is required.

Group Administrator's Information

Group Name _____ **Group Administrator's Signature** _____ **Date Prepared (MM/DD/YYYY)** _____

Medical Group #: _____ **Dental Group #:** _____ **Vision Group #:** _____

Medical Subscriber ID #: __ __ __ __ __ __ __ __ __ **Name:** _____

Cancel Entire Contract

Cancel Code:	Medical Cancel Date:

Cancel Dependents Only

Dependent's Full Name:	DOB:	Cancel Code:	Medical Cancel Date:

Dental Subscriber ID #: __ __ __ __ __ __ __ __ __ **Name:** _____

Cancel Entire Contract

Cancel Code:	Dental Cancel Date:

Cancel Dependents Only

Dependent's Full Name:	DOB:	Cancel Code:	Dental Cancel Date:

Vision Subscriber ID #: __ __ __ __ __ __ __ __ __ **Name:** _____

Cancel Entire Contract

Cancel Code:	Vision Cancel Date:

Cancel Dependents Only

Dependent's Full Name:	DOB:	Cancel Code:	Vision Cancel Date:

Subscriber Cancel Codes:

SB02-Left Employment
SB06-Employee No Longer Wants Coverage* (subscriber request)
SB07-Deceased SB44-Medicare Eligible (Medicare plan with same employer)
SB08-Subgroup Transfer* SB57-Layoff Without Benefits
SB09-Enrolled in Error*
SB58-Change in Employee Eligibility Status

Dependent Cancel Codes:

M010-Overage Dependent
M013-Ineligible Dependent
M003-Subscriber No Longer Wants to Cover Dependent*
M007-Dependent No Longer Wants Coverage*
M011-No Longer a Student
M004-Enrolled in Error*
M002-Deceased* M005-Divorced
M014-YA No Longer Qualifies*
M009-Marriage
M008-Moved Out of Area*
M040-Medicare Same Group*

☐ **ADDRESS CHANGE**
Check box if subscriber's address needs to be changed

Street Address _____

City _____ **State** _____ **Zip** _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature _____ **Date** _____

Please return to P.O. Box 211256 Eagan, MN 55121-2656