C.A.R. HEALTH & LIFE PLANS TERMINATION REQUEST FORM

This termination form is for use ONLY with C.A.R. health and life plans.
RealCare is not responsible for termination of coverage outside of the C.A.R. group plans.

Date: _____ Member ID or Policy #:_____

Subscriber Name: _____
Last First M.I.

Address: _____
Street Address

_____
City State Zip

Phone Number: _____ Email: _____

Please terminate the following coverage effective: _____ ***(Terminations must be effective as of the first of the month. Monthly premium payments are not prorated for terminations and retroactive terminations are usually not allowed.)***

☐ C.A.R. Group Kaiser Medical Plan

☐ C.A.R. Group Anthem Blue Cross Medical Plan *(Include completed/signed Anthem "Employee Waiver Form")*

☐ C.A.R. Group Dental Plan - If dental coverage is terminated, you will not be eligible to re-enroll until the next Open Enrollment following a thirteen-month waiting period.

☐ C.A.R. Group Vision Plan - If vision coverage is terminated, you will not be eligible to re-enroll until the next Open Enrollment following a thirteen-month waiting period.

☐ C.A.R. Group Life Insurance

I am terminating coverage because:

☐ I have obtained replacement coverage from another group

☐ I have obtained replacement coverage from an individual/family plan

☐ I have obtained replacement coverage from Covered California

☐ I don't want the coverage

☐ Other – Please Describe: _____

Subscriber Signature: _____ Date: _____

Fax your completed termination request form to RealCare Billing Department (707) 939-8450 or e-mail to rc-enrollment@nfp.com

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