

REQUEST TO TERMINATE A NON-GROUP PLAN OR REMOVE DEPENDENTS

Instructions:

- To terminate coverage for yourself and all dependents complete sections A, B, and D.
- To remove one or more dependents from your plan complete sections A, C, and D.
- The requested termination date can be a future date, but it cannot be earlier than the date we receive this completed form.
- Return the completed form:

Mail to: Horizon BCBSNJ

Attn: Consumer Terminations 3 Penn Plaza East, PP-09T

Newark, NJ 07105

Fax to: 973-274-4413

Email to: individual application @ Horizon Blue.com

A.	Name (Policyholder):		
	Policyholder Identification #		
	Contact Telephone #		
	Address:	<u>-</u>	
	City:State:	Zip Code:	
B. Terminate the Plan – Coverage for everyone on the plan will end. (Check all that apply)			
	Medical		
	Stand Alone Pediatric Dental (SAPD). If you have a Horizon BCBSNJ medical plan that you		
	intend to keep, you acknowledge that you have purchased a Marketplace certified SAPD plan		
	with Horizon BCBSNJ or another carrier, as is required under Federal law.		
	Dental		
	Vision		
	Requested termination date:		
	noquotica termination date.		
C. Remove a Dependent(s) – Only list dependents you want to remove. (Check all that apply)			
•	[] Spouse/Civil Union Partner/Domestic Partner		
	Name:	Requested termination date:	
	[] Medical [] Stand Alone Pediatric Dental (SAPD)	[] Dental [] Vision	
	[] Child – Attach additional pages if necessary, dated and signed by you.		
	Name:	Requested termination date:	
	[] Medical [] Stand Alone Pediatric Dental (SAPD)	[] Dental [] Vision	
	Name:	Requested termination date:	
	[] Medical [] Stand Alone Pediatric Dental (SAPD)	[] Dental [] Vision	
	Name:	Requested termination date:	
	[] Medical [] Stand Alone Pediatric Dental (SAPD)		
D.	Print Name (Policyholder):		
	Signature:	Date:	