ALFA Health Plans
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# ALFAHP COVERAGE CANCELLATION FORM

| Subscriber Name | Subscriber's Date of Birth |
|---|---|
| Health Plan ID | Dental Plan ID |

☐ **Cancel my coverage.** **(Please see "Coverage Termination" section below.)**

**Reason:** ☐**Obtained Employer Coverage** ☐**Other Individual Coverage** ☐**Affordability**

**Effective Date of Cancellation:** _____/_____/_____

**Subscriber Signature: X**_____**Date:**_____

☐ **Cancel coverage due to death.** **Subscriber Deceased on:** _____/_____/_____

**(Please provide us with the name and address of the Executor of the Estate.)**

**Executor's Name:**_____**Daytime Phone No:**_____

**Mailing Address:**_____

**Executor's Signature: X**_____**Date:**_____

*It is a crime to knowingly provide false, incomplete or misleading information for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.*

***A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.***

## Coverage Termination

You, as a Subscriber, can cancel the Coverage for any reason by giving 10 days written notice to ALFA Health Plans. Your coverage will terminate the following paid-to date.

***Please note - once a cancellation is processed it cannot be revoked. In order to obtain new coverage, medical underwriting for approval and pre-existing condition waiting periods will apply.***

If Coverage terminates as a result of Your death and there are no dependents covered, Coverage ends on the date of death and Your estate is entitled to a refund of any unused premiums.

If You are on a monthly bank draft, You have the option to stop payment at Your bank, provided You present Your bank with the proper account information and exact bank draft amount.

It is Your responsibility to maintain Your current address on file with ALFA Health Plans at all times.