HealthPartners®
Your health. Your partner.℠

Small Group Cancellation Request

We are dedicated to providing you responsive customer service to help your clients reach their health care goals. As part of that commitment, please help us understand how we could have better served your client.

Group name: _____ **Date:** _____

Group number: _____ **Cancellation effective date:*** _____

Coverage type: ☐ Medical ☐ Dental ☐ FSA

Reason for cancellation:
☐ Price ☐ Out of business ☐ Product issues
☐ Features ☐ Customer service ☐ Network issues

☐ Other (please explain): _____

New carrier: ☐ BCBS ☐ Medica ☐ Preferred One
☐ Other _____

Savings percentage: _____ % **Table:** _____

Would you like us to send HIPAA Certificates or individual plan information to your employees:
☐ No ☐ Yes If yes: ☐ HIPAA Certificates and/or ☐ Individual Plan Information

Agent of Record Printed Name: _____

Agent of Record Authorized Signature: _____

Date: _____

*Please submit this form to your HealthPartners group sales representative at least three days prior to your cancellation date. Once received, your cancellation will be processed.

Please email this form to your HealthPartners Sales Team.

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