HealthPartners

Individual Plan Cancellation Form

Return completed and signed form to:

Email: premiumbilling@healthpartners.com
Fax: 952-883-9630
Mail: HealthPartners Membership Accounting
PO Box 297
Minneapolis, MN 55440-0297

Use this form to **cancel all coverage or cancel coverage for specific members** on your HealthPartners Individual plan(s). Answer all applicable questions completely. Submit the completed and signed form along with any applicable documentation to avoid a delay in processing. **This form cannot be used to cancel HealthPartners coverage purchased through MNsure or the Federally Facilitated Marketplace.**

ⓘ **Questions?** Contact HealthPartners Membership Accounting at **952-883-5353** or **888-827-0181**, Monday – Friday, 8 a.m. – 5 p.m.

POLICYHOLDER INFORMATION

ⓘ Policyholder information must be completed.

Last name	First name	Middle initial	HealthPartners member number

Date of birth	Preferred telephone number	Alternate telephone number

CANCELLATION OF COVERAGE[1]

ⓘ Provide information on the plan(s) and member(s) you would like to cancel.

☐ Individual medical plan – **Contract number:**	**Requested cancellation date:**
☐ Individual dental plan – **Contract number:**	☐ **Check box** if switching to a new HealthPartners plan[2].

ⓘ This form must be received prior to the requested cancel date. If received after the requested cancel date, the cancellation will be received date.

If your premiums are automatically paid, you must notify us or log on to your healthpartners.com account by the 20th of the current month to stop future payments from being withdrawn.

Please indicate who to cancel[3].

☐ Cancel all coverage for the plan(s) ☐ Cancel all dependents only on the plan(s)

☐ Cancel coverage only on member(s) listed below[4]

If not canceling all coverage, indicate members to cancel below. Add additional pages if needed.

	Last name	First name	Middle initial	Date of birth
1				
2				
3				

REASON FOR CANCELLATION

ⓘ Indicate reason for cancellation and provide information, if applicable

☐ Obtained other coverage ☐ Member starting Medicare – Medicare start date: _____

☐ Death – Date of death: _____ Name of deceased: _____

☐ Other: _____

ⓘ **You must sign and complete the next page of this form and all pages of this form must be submitted. Processing of your requested changes will be delayed if information and/or pages are missing from this form.**

GENERAL INFORMATION

[1]Cancel requests must be received by HealthPartners prior to the requested cancel date. If this request is received after the requested cancel date, coverage will be canceled as of the date this form is received by HealthPartners. Cancel requests received without a requested date will by default be canceled the last day of the month in which the form was received. If premiums are automatically withdrawn, HealthPartners must receive the cancellation request by the 20th of the month to prevent future premium withdrawals. Premium credit resulting from cancellation of the full policy will be refunded to the policyholder within four weeks. Any premium credit resulting in the removal of dependents from coverage will be applied to future premium payments on the policy.

[2]If you are switching to new HealthPartners coverage, your cancel date will be the effective date of the new HealthPartners coverage.

[3]The policyholder has the authority to cancel all coverage and coverage for any dependents on the plan. Dependents age 18 and over have the authority to remove only themselves from coverage.

[4]If only the policyholder is being removed from coverage, the spouse covered becomes the policyholder. If there is no spouse covered on the plan, the youngest child becomes the policyholder.

CONDITIONS OF ACCEPTANCE

ⓘ Policyholder must sign below or dependent 18 and over must sign below if requesting removal from coverage.

Authorization and Representation

I authorize HealthPartners to make the change(s) noted on this form to my Individual medical and/or personal dental plan for myself and all dependents, if applicable, covered under my policy.

I acknowledge that this cancellation request is a voluntary cancellation of myself and/or any applicable dependents as indicated on this form.

If I am canceling medical coverage, I understand that I and/or my dependents may not be able to re-enroll in minimum essential individual medical coverage without a qualifying life event or until the annual open enrollment period. If I am canceling personal dental coverage, I understand that I and/or my dependents may not be able to re-enroll in a HealthPartners individual dental plan for a period of up to two years.

ⓘ **Written signatures are required, electronic signatures cannot be accepted.**

Signature of policyholder	Date

Signature of canceling dependent 18 or older*	Date

*Only required if the dependent is submitting the request to be removed from the plan.

If policyholder is under age 18, please have an authorized legal guardian sign.

Signature of legal guardian	Date

If applicable, relationship of legal guardian to policyholder

Broker name, if applicable (Please print)	Broker number	Date

ⓘ **The policyholder signature and all other applicable signatures are still required on cancel forms submitted by a broker.** The broker indicated above must be the assigned broker on this policy. The assigned broker cannot be changed with this form.

HEALTHPARTNERS USE ONLY

Information below to be completed by HealthPartners Membership Accounting.

Cancellation date:	New contract if applicable:	Billing verified:	Follow-up complete:	Processed by:	Audited by: