



**Return this form to:**

Coventry Health Care, Inc.  
Attn: Enrollment Dept  
P.O. Box 7756  
London, KY 40742

Toll Free Fax Number: (866) 294-4301  
Toll Free Voice Number: (866) 364-5663

**CONTRACT TERMINATION FORM**

Per the terms in your policy you may terminate Coverage for yourself and any Enrolled Dependents for any reason **with advance written notice.**

You may use this form to make your request. An incomplete form may delay the processing of your request.

Member Name: \_\_\_\_\_

Member Address: \_\_\_\_\_

Identification Number: \_\_\_\_\_

Member's Phone number: \_\_\_\_\_

Requested Cancellation Date: \_\_\_\_\_

**Subscriber's Termination Request**

Entire Policy    Subscriber only (if Policy includes Dependents)    Dependent(s) Only (list below)

Please list the **Dependent Individuals** to be terminated from the policy. **Use additional paper if needed.**

Last,	First	Middle Initial	Member ID#

**Termination Reason**

In order for Coventry Health Care, Inc. to accurately report Health Care Statistics, please provide a reason for the termination by checking the most appropriate box.

- Premium Rate    Service provided by Coventry    Participating Provider Network
- Benefits    Moving out of Coverage Area    Eligible for Employer Coverage
- New Carrier    Free Look Period    No Coverage

Other (please explain): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

A signature must be included for all dependents 18 and older.