Horizon Blue Cross Blue Shield of New Jersey

RESET

REQUEST FOR TERMINATION

Horizon Blue Cross and Blue Shield of New Jersey
ATTN: Consumer Terminations
3 Penn Plaza East, PP-09T
Newark, NJ 07105
Fax: 973 274 4413
Email: individualapplication@horizonblue.com

Instructions: This form is to be used to request termination of a direct payment (non-group) policy.

Name *(Policyholder):*_____

Policyholder Identification #: _____

Contact Telephone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Plan Requested - Please terminate the following policy (or policies) with Horizon Blue Cross Blue Shield of New Jersey (check all that applies):

[ ] Medical

[ ] Stand Alone Pediatric Dental (SAPD). I acknowledge that I have purchased a Marketplace certified SAPD plan with another carrier that is required under Federal law.

Requested Termination Date - _____The requested termination date can be a future date, but it cannot be earlier than the date you complete and sign this form.

Reason for termination (optional):

☐ Enrolled with another plan ☐ Eligible for a subsidy

☐ Current premium too high ☐ Member deceased

Other (please describe): _____

Print Name _____

Signature: _____ Date: _____