

## REQUEST TO TERMINATE A NON-GROUP PLAN OR REMOVE DEPENDENTS

## **Instructions:**

- To terminate coverage for yourself and all dependents complete sections A, B, and D.
- To remove one or more dependents from your plan complete sections A, C, and D.
- The requested termination date can be a future date, but it cannot be earlier than the date we receive this completed form.
- Return the completed form:

Mail to: Horizon BCBSNJ

Attn: Consumer Terminations 3 Penn Plaza East, PP-09T

Newark, NJ 07105

Fax to: 973-274-4413

Email to: individual application @ Horizon Blue.com

Policyholder Identification # Contact Telephone # Address: City: State: Zip Code:  B. Terminate the Plan – Coverage for everyone on the plan will end. (Check all that apply)  Medical Stand Alone Pediatric Dental (SAPD). If you have a Horizon BCBSNJ medical plan that you intend to keep, you acknowledge that you have purchased a Marketplace certified SAPD plan with Horizon BCBSNJ or another carrier, as is required under Federal law.  Dental Vision  Requested termination date:  C. Remove a Dependent(s) – Only list dependents you want to remove. (Check all that apply) [] Spouse/Civil Union Partner/Domestic Partner  Name: Requested termination date: [] Medical [] Stand Alone Pediatric Dental (SAPD) [] Dental [] Vision  Name: Requested termination date: [] Medical [] Stand Alone Pediatric Dental (SAPD) [] Dental [] Vision  Name: Requested termination date: [] Medical [] Stand Alone Pediatric Dental (SAPD) [] Dental [] Vision  Name: Requested termination date: [] Medical [] Stand Alone Pediatric Dental (SAPD) [] Dental [] Vision  Name: Requested termination date: [] Medical [] Stand Alone Pediatric Dental (SAPD) [] Dental [] Vision	A.	Name (Policyholder):		
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