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: individualapplication@**HorizonBlue.com**

A. Name (*Policyholder):*_____
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

☐ Child – Attach additional pages if necessary, dated and signed by you.

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

D. Print Name *(Policyholder)*:_____

Signature: _____ **Date:** _____