

Please Mail Complete Form to: MCHA/Medica, Mn015-2838, 4316 Rice Lake Road, Duluth, MN 55811
 Or Fax Complete Form to: MCHA/Medica Enrollment at 218-279-6493



CANCELLATION FORM

Name	MCHA Member Number
Street Address	Medicare Number
City, State, Zip Code	Birth date: month/day/year

MCHA terminates coverage the end of the month in which the Cancellation Form is received by MCHA or on the date of death. I wish to cancel my Minnesota Comprehensive Health Association (MCHA) Insurance coverage effective _____.

Member Signature

Today's Date

Or signature of legally authorized representative (Executor, attorney-in-fact, conservator, or guardian. Proof of authorization must be attached).

REASON FOR CANCELLATION IS: (Please check one)

- Eligible for and elected coverage under an employer group policy in the market. (323)
- Eligible for and elected a Medicare supplement policy in the market. (340)
- No longer an eligible dependent child under the plan (dependent child reaching limiting age of 25, due to death of the enrollee, dissolution of enrollee marriage, or received other policy coverage). (320)
- No longer an eligible dependent spouse under the plan (dissolution of marriage, due to death of the enrollee, enrollee becomes covered under Medicare, or received other policy coverage). (327)
- MCHA premium is too expensive / unable to continue to afford premiums. (310)
- Dissatisfaction with MCHA coverage. (309)
- Moved outside the state of Minnesota. (343)
- Death/Date: _____ (306)
- Other - Please explain: _____ (324)

The MCHA "Policy of Coverage" defines continuation of coverage provisions for dependents due to: the death of the enrollee, dissolution of marriage, an enrollee's enrollment for benefits under Medicare and a dependent child ceasing to be a dependent child as of the limiting age of 25. Continuation of coverage may be limited to up to 36 months (see policy provisions). If continuation of coverage will be elected, please list dependent names and social security numbers:
