

Group Termination Request

All sections must be completed before termination request will be processed.

Group ID _____ - _____

Group name _____

Phone _____ - _____ - _____

Current company address _____

New mailing address _____

**Primary reason for termination
(choose one):**

- Business closed Business sold
- Cost of premiums/rates
- Moving to another Kaiser Permanente **group** plan effective ____/____/____
 - ___ CalChoice
 - ___ Choice Solutions
 - ___ Other
- Moving to another Kaiser Permanente **individual** plan effective ____/____/____
 - ___ Conversion plans
 - ___ Health Insurance Portability and Accountability Act of 1996 (HIPAA) plans
 - ___ Kaiser Permanente for Individuals and Families plans
 - ___ Kaiser Permanente Senior Advantage (Medicare)
- Changed to other insurance carrier/provider.
Please provide name of carrier here:

**Please select other reason(s) for termination
(choose all that apply):**

- Found less expensive plan
- Uninsured
- Dissatisfied with benefits
 - ___ Flexibility of copayment
- Dissatisfied with plan/product selection
 - ___ Catastrophic
 - ___ High deductible
 - ___ HRA/HSA
 - ___ Out-of-area coverage
 - ___ PPO plan
- Dissatisfied with plan administration
 - ___ Member enrollment/billing
 - ___ Renewals
- Dissatisfied with patient service/care
 - ___ Access
 - ___ Physician selection

Please terminate group membership effective the first of _____ (month), _____ (year). Unless a balance is owed on your account, your account will be terminated either on the date of membership termination above or on the first of the month after 15 days from receipt of this document by Kaiser Permanente, whichever is later.

Authorized contract signer _____
Print name
Signature
Date

Please fax completed form to:
1-858-614-3344 (Northern California) **1-858-614-3345** (Southern California)