Termination Form

Individual and Family Plans

How to use this form:

Subscribers, or brokers on their behalf, may use this form to request termination of their coverage. If we receive the termination notice on or before the last day of the month, the coverage termination will be effective the first day of the following month. For additional information on coverage termination requests, please refer to your Evidence of Coverage and Disclosure Form.

Please use the Individual and Family Plan Application/Enrollment/Change Form for new enrollment or change requests.

How to submit this form:

You must email or fax your signed and completed form to Sutter Health Plus. Missing information may delay processing your request.

EMAIL
shpbilling@sutterhealth.org

FAX
916-736-5090

Need Assistance?

If you have questions about completing this form, please contact Sutter Health Plus Member Services at 855-315-5800 (TTY: 855-830-3500), Monday through Friday from 8 a.m. to 7 p.m. Sutter Health Plus can provide translation services and other language assistance services to you free of charge.

Subscriber/Dependent First and Last Name	Date of Birth	Termination Effective Date	Member Identification Number

Subscriber/Financially Responsible Party/Broker Signature **Date**

Sutter Health Plus
Your Health Plan