UPMC HEALTH PLAN

Authorization to Cancel
UPMC Health Plan Group Coverage

Thank you for your participation in UPMC Health Plan group insurance coverage. It has come to our attention that you wish to terminate your group coverage at this time. To do so, please complete and sign this Authorization to Cancel UPMC Health Plan Group Coverage form and return it as soon as possible to the following address:

UPMC Health Plan
One Chatham Center, Suite 800
112 Washington Place
Pittsburgh, PA 15219

By signing below, I hereby authorize my group coverage to be terminated:

Group Name: _____

Group Number: _____

Requested Termination Date: _____

(Please note that termination notice should be given at least 30 days before the requested termination date. Group will not be permitted to terminate retroactively.)

Reason for termination (*check all that apply*):

☐ **Cost**
☐ **Obtained other coverage** (carrier's name): _____
☐ **Other:** _____
(please specify)

Would you like to be contacted by a UPMC Health Plan representative? ☐ Yes ☐ No

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Employer contact information:

Group contact name: _____ **Title:** _____

Group contact signature: _____ **Date:** _____

White Copy: UPMC Health Plan Yellow Copy: Association Pink Copy: Employer