# Request to Terminate/Cancel CHIP Coverage

Illinois Comprehensive Health Insurance Plan (CHIP)
www.chip.state.il.us

If you wish to terminate/cancel your CHIP health insurance coverage, complete, sign, and return this form to the following address:

Illinois Comprehensive Health Insurance Plan
P.O. Box 2401
Chicago, IL 60690 or fax to 312-861-1661

_____ _____
*print name* *identification number*

_____ Provide the date you want to terminate your coverage effective midnight.
*terminate date*

I understand that I will not be eligible for CHIP coverage again until 12 months have elapsed unless I can qualify as a Federally Eligible Individual.

The reason I want my CHIP insurance to terminate is:

- ☐ I have obtained other health insurance (provide documentation of the effective date if available).
- ☐ Medicare (submit copy of Medicare card)
- ☐ I have been approved to receive medical assistance (such as All Kids) from the Illinois Department of Healthcare and Family Services or like agencies.
- ☐ I moved outside of Illinois on _____ and am no longer a resident of Illinois.
  *date*
- ☐ Premium too expensive
- ☐ Other (please explain): _____

_____

**If you are currently paying by Monthly Bank draft you must provide 15 days' written notice to stop your bank draft.**

_____ _____
*signature of participant* *date*

_____ _____
*signature of custodial parent or legal guardian if participant is a minor or legally incompetent.* *date*