Return this form to:
Mailing Address: CoventryOne
Attn: Billing and Enrollment
P.O. Box 31210
Tampa, FL 33630-3210

Toll Free Fax Number: 1-877-899-6447

CONTRACT TERMINATION FORM

Per the terms in your policy you may terminate Coverage for yourself and any Enrolled Dependents for any reason **with advance written notice.**

You may use this form to make your request. An incomplete form may delay the processing of your request.

Member Name: _____

Member Address: _____

Identification Number: _____

Member's Phone number: _____

Requested Cancellation Date: _____

Subscriber's Termination Request

☐Entire Policy ☐Subscriber only (if Policy includes Dependents) ☐Dependent(s) Only (list below)

Please list the **Dependent Individuals** to be terminated from the policy. **Use additional paper if needed.**

Last,	First	Middle Initial	Member ID#
Last,	First	Middle Initial	Member ID#

Termination Reason

In order for Coventry Health Care, Inc. to accurately report Health Care Statistics, please provide a reason for the termination by checking the most appropriate box.

☐Premium Rate ☐Service provided by Coventry ☐ Participating Provider Network
☐Benefits ☐Moving out of Coverage Area ☐ Eligible for Employer Coverage
☐New Carrier ☐Free Look Period ☐ No Coverage
☐Other (please explain): _____

Signature:_____Date: _____

Signature:_____ _____ Date: _____
A signature must be included for all dependents 18 and older.