HEALTH TRADITION

65Plus - Cancellation Form

Instructions: Use this form to terminate your policy.
Your termination request must be received before the 1st of the month in which you want your coverage to be canceled. Please allow us a reasonable amount of time to stop any automatic withdrawals of premium payments from your bank account. Any premium overpayment will be refunded back to you.

Send to: Health Tradition Health Plan
PO Box 21171
Eagan, MN 55121

Fax: 608.781.9654

Member Information

Last Name	First Name	MI

Mailing Address	City	State	Zip Code

Member ID Number HT	Premium Billing Account Number
Telephone Number	Date of Birth / /

Requested Termination Date (last day of coverage)

Date / /

Coverage will end on the last day of the current month or the end of the month requested by the subscriber in such written notice, whichever is later.

Subscriber or Authorized Representative Signature **X**	Signature Date / /