

Health Tradition Health Plan Notice of Termination

Health Tradition 65Plus members must provide a notice of health plan termination when moving to a new health plan. Please complete the requested information, sign and date this form.

If you, the primary member (or subscriber) of the health plan, also have a spouse on the health plan, please complete their information as well.

Once you have completed the form, you can email it to Eligibility@HealthTradition.com or mail to the following address:

Health Tradition
PO Box 21171
Eagan, MN 55121

PRIMARY MEMBER (SUBSCRIBER) INFORMATION	
Primary Member (Subscriber) Name:	Primary Member (Subscriber) Date of Birth:
Primary Member (Subscriber) ID Number:	Requested Date of Termination (month/date/year):

SPOUSE INFORMATION, <u>IF APPLICABLE</u>	
Spouse's Name (if applicable):	Spouse's Date of Birth (if applicable):
Spouse's ID Number (if applicable):	

Primary Member (Subscriber) Signature _____
Date

Spouse's Signature _____
Date

