Members HealthPlan NJ
Designed for You.

Please send forms to:
Concord Management Resources
P.O. Box 5487
Somerset, NJ 08875
Phone: 833-MEWANOW (833-639-2669)
Fax: 833-MEWAFAX (833-639-2329)
Email:

HEALTH PLAN TERMINATION FORM

Section 1: Employer Information

Employer Name (Practice Name): _____

Federal Tax Identification #: _____

To be completed by Trust (Plan Sponsor)
Group # **Account #**

Address: _____
Street Address Suite City State Zip

Phone: _____ Fax: _____ E-Mail Address: _____

Section 2: Reason for Termination

Group is terminating the group from Members Health Plan NJ because (check ALL boxes that apply):

❑ **Rates too high**
Moving to: ❑ Horizon ❑ Aetna ❑ Cigna ❑ United ❑ Amerihealth ❑ Oscar ❑ Homestead ❑ Exchange ❑ Other
Savings: ❑ 1%-2% ❑ 3%-4% ❑ 5% ❑ 6%-9% ❑ 10%-14% ❑ 15% ❑ 16%-19% ❑ 20% ❑ 21%+

❑ **Service issues** (briefly explain) _____
Moving to: ❑ Horizon ❑ Aetna ❑ Cigna ❑ United ❑ Amerihealth ❑ Oscar ❑ Homestead ❑ Exchange ❑ Other

❑ **Business reducing costs** (briefly explain) _____
Moving to: ❑ Horizon ❑ Aetna ❑ Cigna ❑ United ❑ Amerihealth ❑ Oscar ❑ Homestead ❑ Exchange ❑ Other

❑ **Increased Benefits** (briefly explain) _____
Moving to: ❑ No Deductible ❑ Lower Co-pay ❑ Better Network ❑ Less Out of Pocket ❑ Increased Surgical Coverage
❑ Increased Hospitalization Coverage ❑ Increased Imaging Coverage ❑ Increase Diagnostic Testing Coverage

❑ **No longer offering medical benefits to employees**

❑ **No longer have any employees eligible for benefits**

❑ **Closing business**

❑ **Merging with another business**

❑ **Other** (briefly explain)_____

Section 3: Termination Agreement

I/we hereby request that coverage for all employees enrolled under Members Health Plan NJ be terminated effective _____. I understand that Members Health Plan NJ is responsible only for the expenses incurred while this coverage was in force. This letter will provide your group with the required 60-day termination notification of Members Health Plan NJ.

I/we understand that the responsibility of offering continuation coverage or COBRA coverage to my/our employees lies with the employer. If new coverage from another carrier is not being purchased, then, I/we must take responsibility for offering continuation coverage or COBRA to all covered employees.

Name (Please Print): _____

Signed: _____ **Date**: _____

Section 4: To be filled out by Trust (Plan Sponsor)

O *Group has been Terminated on* _____, _____.

_____ **Date**: _____
Authorized Representative of Members Health Plan NJ