RESET

REQUEST FOR TERMINATION

Horizon Blue Cross and Blue Shield of New Jersey
ATTN: Consumer Terminations
3 Penn Plaza East, PP-09T
Newark, NJ 07105
Fax: 973 274 4413
Email: individualapplication@horizonblue.com

Instructions: This form is to be used to request termination of a direct payment (non-group) policy.

Name *(Policyholder)*: _____

Policyholder Identification #: _____

Contact Telephone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Plan Requested - Please terminate the following policy (or policies) with Horizon Blue Cross Blue Shield of New Jersey (check all that applies):

☐ Medical

☐ Stand Alone Pediatric Dental (SAPD). If you have a Horizon BCBSNJ medical plan that you intend to keep, you acknowledge that you have purchased a Marketplace certified SAPD plan with Horizon BCBSNJ or another carrier, as is required under Federal law.

☐ Dental

☐ Vision

Requested Termination Date - _____ The requested termination date can be a future date, but it cannot be earlier than the date we receive this completed form.

Print Name: _____

Signature: _____ Date: _____