



Horizon Blue Cross Blue Shield of New Jersey

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). I acknowledge that I have purchased a Marketplace certified SAPD plan with another carrier that 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: _____