Chorus Community Health Plans
PO Box 1997 - MS 6280 | Milwaukee, WI 53201-1997
Toll-free: 1-844-708-3837 | chorushealthplans.org

Off Exchange Policy Cancellation Form

Please print clearly. Keep a copy of the completed form for your records. If you have any questions, contact Member Sales at 1-844-708-3837 or your producer/insurance agent.

This form is for policies purchased directly through Chorus Community Health Plans. If you have purchased your policy through the Federally Facilitated Marketplace, please contact 1-800-318-2596 to cancel your coverage.

I want to cancel my policy

POLICYHOLDER LAST NAME	POLICYHOLDER FIRST NAME	POLICYHOLDER MI	MEMBER ID NO.

I want to cancel coverage for these members

MEMBER LAST NAME	MEMBER FIRST NAME	MEMBER MI	MEMBER ID NO.

Requested Termination Date*: _____

*Coverage will end at 11:59pm CST on the requested termination date

Reason for cancellation

Please check all that apply:

- ☐ Obtained employer-based insurance
- ☐ Benefits do not meet my needs
- ☐ Moving out of the area
- ☐ Premium is too high
- ☐ Death
- ☐ Other: _____
- ☐ Divorce
- ☐ Disinterest in plan

Internal Reference: COR Broker Form – OE Cancellation Form (2022.0724)

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Terms and Conditions

This coverage shall terminate on one of the following dates:

- The date requested on this form.
- If no date has been requested: As of the 1st of the following month after we receive the covered members written request to terminate coverage.

Please note that when the Policyholder cancels coverage, coverage is canceled for everyone on the Policy. Upon receipt of this form, coverage will end as of 11:59pm CST on the date requested on this form. For example, if a member terminates coverage with a May 31st termination date, their coverage will end at 11:59pm CST on May 31st, and they will no longer be covered starting June 1st.

If it is not your intent to cancel everyone on the policy, please contact Member Sales at 1-844-708-3837 or your licensed insurance producer/agent. A new application for any remaining family members is required.

If premium refunds are due because of a termination, they will be processed within four to six weeks of the cancellation request.

POLICYHOLDER SIGNATURE _____ DATE _____

Please return this completed form to:

Fax: 414-266-1611

Email: CCHP-MemberSales@chorushealthplans.org for Members
CCHP-BrokerSupport@chorushealthplans.org for Brokers

Mail: Chorus Community Health Plans
P.O. Box 1997, MS 6280
Milwaukee, WI 53201-1997