P.O. Box 2156
Pohnpei, FSM 96941
Email: info@micareplan.fm

PLAN CANCELLATION REQUEST

LAST	FIRST	MI	INSURANCE ID NUMBER

Employer Name			
Phone Numbers	Home:	Cell:	Work:
Email:			

- I hereby request with MiCare Health Insurance Plan to cancel my Plan including all dependents covered under my plan.
- I understand that the Cancellation Request will be **effective on the 1st day of October**.
- I understand that I am still responsible for the biweekly or monthly premium payments until the effective date of my cancellation.
- I understand that I am still liable to pay off any and all outstanding patient share balances, incidentals, and dues incurred by me or my dependent during the life of the Plan.
- I understand that there is a **24 month waiting period** before I can reapply to MiCare upon the Cancellation of my Plan.
- Reason for my cancellation is:_______________________________________
- This Cancellation Request terminates all coverages, benefits, and services associated with my Plan.

Signature of Enrollee: ___________________________________ Date: _____________

OFFICE USE BELOW

Received by MiCare:

Employee Signature: ____________________________________ Received Date: _____________

Print Name: ____________________________________