Vytra HEALTH PLANS

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631-694-6565

Notice of Change / Termination Form

Today's Date _____

Group Name _____ **Authorized By:** _____

Subscriber Name	Vytra ID #	Group No.	Effective Date of Change / Term	Reason for Change / Terminations *(Please state reason or enter code below)*

Please note that termination information must be remitted to Vytra Health Plans prior to the 15th of the month in order for the enrollment changes to be reflected on your next billing statement. Retroactive terminations may not exceed 30 days.

Reason For Termination

1- Termination of employment
2- Covered under other insurance *(i.e. spouse)*
3- No longer eligible for coverage
4- Medicare eligible
5- Dissatisfaction of service
6- Dissatisfaction with plan benefits
7- Dissatisfaction with network/physician access
8- Not affordable
9- Obtained a lower price from another carrier
10- Other *(please specify)*