OXFORD HEALTH PLANS®

A UnitedHealthcare Company

# Group Termination Form

Oxford Health Plans (NY), Inc. • Oxford Health Insurance Inc.

**Please return this form to:** P.O. Box 7085, Bridgeport, CT 06601-7085

## I. GROUP IDENTIFICATION

1. **Group name** _____

2. **Group number:** _____

***Important Information***

- Please submit your termination request 30 days prior to the date you wish to terminate.
- Please refer to your Group Enrollment Agreement (GEA) for details on terminating your group's policy.
- If you have questions regarding this form, please contact your Dedicated Group Service Team.

3. **Requested date of Group termination:** __ __ – __ __ – __ __

4. **Reason for Termination:** ❒ Benefits ❒ Rates ❒ Service ❒ Other _____

_____

Signature Date Title

**Please Note: In order to execute a group termination request, a signature from an authorized person is required. Signature must be from the President, Owner, Current BA, Vice President, Director, Executive Officer or other high official at the group.**