

**GROUP TERMINATION REQUEST****IMPORTANT INFORMATION**

If you have questions on how to complete this form, **please contact your Account Manager**. All sections must be completed before termination requests will be processed. If your group pays its premium through autopay, it is your responsibility to stop autopay once all premium owed has been paid. If you have questions on how to stop autopay, please call Georgia Employer and Broker Services at **404-364-3814**.

**1. COMPANY INFORMATION**

Company Name: \_\_\_\_\_

Group ID: \_\_\_\_\_

**2. TERMINATION DATE**

Unless a balance is owed to your account, your account will be terminated on the termination date below (a group termination can be processed in the month received or future month.)

Termination effective date: \_\_\_\_\_

Broker of Record: \_\_\_\_\_

Contract effective date: \_\_\_\_\_

**3. REASON FOR TERMINATION**

Please select the primary reason. Choose only **one option** below:

- |   |   |
|---|---|
| <input type="checkbox"/> Chose Self-funded/Level-funded                         | <input type="checkbox"/> Received Competitor Discount/Rates not Competitive |
| <input type="checkbox"/> Migrated Membership to Exchanges                       | <input type="checkbox"/> Group Dropped Coverage, with no Replacement        |
| <input type="checkbox"/> Dissatisfaction with Access to Care/Care Received      | <input type="checkbox"/> Out of Business/Closed Regional Operations         |
| <input type="checkbox"/> Dissatisfaction with KP Network/Service Area Locations | <input type="checkbox"/> Purchased/Merged with Another Company              |

Comments: \_\_\_\_\_

Please select the secondary reason. Choose **multiple options** below:

- |   |  |
|---|--|
| <input type="checkbox"/> Dissatisfaction with Admin Services/Claims             | <input type="checkbox"/> Dissatisfaction with Cost of Premiums/Rates |
| <input type="checkbox"/> Dissatisfaction with Plan/Benefit Offerings            | <input type="checkbox"/> Dissatisfaction with PPO/Out of Area Design |
| <input type="checkbox"/> Dissatisfaction with Access to Care/Care Received      | <input type="checkbox"/> Out of Business/Closed Regional Operations  |
| <input type="checkbox"/> Dissatisfaction with KP Network/Service Area Locations | <input type="checkbox"/> Purchased/Merged with Another Company       |

**Alternate Insurance**

Please select only **one option** below, if applicable:

- |                              |   |   |                                   |
|------------------------------|---|---|-----------------------------------|
| <input type="checkbox"/> ACA | <input type="checkbox"/> Level-Funded/Self-Funded | <input type="checkbox"/> Exchanges (Individual) | <input type="checkbox"/> Medicare |
|------------------------------|---|---|-----------------------------------|

**Alternate Carrier**

Please select only **one option** below, if applicable:

- |                                |  |  |                                 |   |   |
|--------------------------------|--|--|---------------------------------|---|---|
| <input type="checkbox"/> Aetna | <input type="checkbox"/> Anthem/Blue Cross | <input type="checkbox"/> Cigna + Oscar | <input type="checkbox"/> Humana | <input type="checkbox"/> UnitedHealthcare | <input type="checkbox"/> Other (specify): _____ |
|--------------------------------|--|--|---------------------------------|---|---|

**4. READ AND SIGN**

I affirm that I am authorized to contract on behalf of the group with Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company, and I am authorized to submit this termination request on behalf of the group. I represent that all the information provided is true and accurate to the best of my knowledge

Authorized company signer (print name)

Company title (print name)

Signature

**X**

Date

*Note: Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and 2) the KPIC Dental plans*

**5. CONTACT INFORMATION**

Please email completed form to **service.issues-ga@kp.org**.