KAISER PERMANENTE®

Small Business

GROUP TERMINATION REQUEST

Fax: **800-369-8010**

All sections must be completed before termination request will be processed.

1 COMPANY INFORMATION

Company name				Customer ID	
Street address		City	State	ZIP	County
Office phone ( ) –	Ext.	Fax ( ) –	Email		

2 PRIMARY REASON FOR TERMINATION

Choose only one option below:

- ☐ Went out of business
- ☐ Business sold
- ☐ Business moved out of area
- ☐ Cost of premiums/rates*
- ☐ Moving to another Kaiser Permanente group plan effective ____/____/_____
  - ☐ Cal*Choice*®
  - ☐ Large line of business
  - ☐ Relocating
  - ☐ Other: _____
- ☐ Moving to a Kaiser Permanente individual plan effective ____/____/_____
  - ☐ Kaiser Permanente for Individuals and Families plans
  - ☐ Kaiser Permanente Senior Advantage (Medicare)
- ☐ Moving to Covered California - Kaiser Permanente plan
- ☐ Moving to Covered California - Non–Kaiser Permanente plan
- ☐ Moving to Covered California - provider/plan unknown
- ☐ Changed to other insurance carrier/provider*
  Carrier name: _____

*Please complete section 3.

3 OTHER REASONS FOR TERMINATION

Choose all that apply:

- ☐ Bankruptcy
- ☐ New owner
  - ☐ does not offer Kaiser Permanente
  - ☐ does not offer benefits
- ☐ Found less expensive plan
- ☐ Dissatisfied with benefits
- ☐ Dissatisfied with plan/product selection
- ☐ Dissatisfied with plan administration
- ☐ Dissatisfied with patient service/care

4 TERMINATION DATE

Please terminate group membership effective the first of _____ (month), _____ (year). Unless a balance is owed on your account, your account will be terminated either on the date of membership termination above or on the first month after 15 days from receipt of this document by Kaiser Permanente, whichever is later.

5 SIGNATURE

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

I affirm that I have authority to contract with Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company (KPIC) on behalf of the group.

Authorized company signer (please print name)	Title (please print)
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.