MEMBER TERMINATION FORM

UHA HEALTH INSURANCE

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INSTRUCTIONS: Use this form to terminate benefit plans for subscribers and/or their family members.

1

Group Name: _____ Group/Division #: ____/____

Prepared By: _____ Contact Number: _____ Page: ____ of ____

MEMBERS

List the members that are no longer eligible for benefits. * By selecting a "Subscriber" option, it will terminate plan for the whole family.

2

Check ONE: ☐ Subscriber * ☐ Spouse/Civil Union Partner ☐ Dependent

Member ID: _____ - ____ Plan Term Date: (Last day of the month) __ / __ / ____

Last Name: _____

First Name: _____

Check ONE: ☐ Subscriber * ☐ Spouse/Civil Union Partner ☐ Dependent

Member ID: _____ - ____ Plan Term Date: (Last day of the month) __ / __ / ____

Last Name: _____

First Name: _____

Check ONE: ☐ Subscriber * ☐ Spouse/Civil Union Partner ☐ Dependent

Member ID: _____ - ____ Plan Term Date: (Last day of the month) __ / __ / ____

Last Name: _____

First Name: _____

Check ONE: ☐ Subscriber * ☐ Spouse/Civil Union Partner ☐ Dependent

Member ID: _____ - ____ Plan Term Date: (Last day of the month) __ / __ / ____

Last Name: _____

First Name: _____

The Group Administrator and subscriber of the above named UHA Member Group certifies by signature below that the above named subscriber is a bona fide employee as defined by the Hawaii Prepaid Healthcare Act. UHA may terminate coverage for any ineligible enrollee upon confirmation of ineligibility. If enrollment of the above named enrollee(s) is found to be based on fraud or intentional misrepresentation of a material fact by the employer, coverage for the Member Group and/or the enrollee(s) may be terminated by UHA. In the event of termination, the above named Member Group agrees that any benefit payments made by UHA on behalf of the ineligible enrollee(s) must be returned in full to UHA by the ineligible enrollee(s) and/or the employer. UHA shall return all premiums paid by the employer with respect to the ineligible enrollee(s) upon termination of coverage and reimbursement of benefit payments made by UHA.

3 Group Administrator Signature: _____ Date: _____

Member Termination Instructions

UHA
HEALTH INSURANCE

① GROUP INFORMATION:
Enter the group name and the eight-digit group/division number.
Provide the name of the person preparing this form and contact phone number.
If multiple pages are being submitted, indicate the page number(s).

② TERMINATION INFORMATION: One subscriber per row.
For each row, provide a subscriber member ID and full name.
Select the member that will be terminated from the plan.
- Selecting subscriber will terminate the plan for the whole family.
- If terminating spouse, civil union partner, or dependent, make the appropriate selection and provide the member's full name.
Provide the month and year of the termination. Termination will fall on the last day of the month selected.

③ GROUP ADMINISTRATOR SIGNATURE: Form must be signed and dated by an authorized group administrator.

To ensure proper processing, all required fields must be completed.
Fax or mail completed forms to:

UHA Employer Services
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Toll-free fax: (877)222-3198

If you have any further questions contact Employer Services.
Phone: (808) 532-4007; Toll-free phone: (800) 458-4600 Ext. 299; www.uhahealth.com