Individual & Family Plan: Cancellation Request

Today's Date: _____/_____/_____ (MM/DD/YYYY)

Subscriber's Name: _____

Subscriber's Date of Birth: _____/_____/_____ (MM/DD/YYYY)

Subscriber's ID #: _____

I, _____, request to cancel the individual plan effective _____.
I understand a 30 day notification is required. If applicable, I will not be eligible for future enrollment until a minimum of 24 months has elapsed since my termination date.

I am voluntarily terminating coverage due to the following reason(s):

- ☐ Moving out of the state of AZ
- ☐ Have financial hardship
- ☐ Have acquired other insurance through another carrier
- ☐ Have had Individual Plan coverage with Delta Dental of Arizona for over 1 year
- ☐ Subscriber is deceased

_____

Subscriber's Signature

_____ _____

Name (If completing on behalf of deceased subscriber) Signature (If completing on behalf of deceased subscriber)

Please forward completed form to:

Delta Dental of Arizona
Individual Plan Enrollment
PO Box 43000
Phoenix, AZ 85080-3000

Direct 602.588.3624
Toll-Free 800.352.6132
Fax 602.548.5075
Email enrollment@deltadentalaz.com