



## CANCELLATION FORM

Name	Medical Assistance Identification Number
Street Address	Medicare Number
City, State, ZIP Code	Birthdate

I am requesting to cancel my application to enroll in (check-one):

- Medica DUAL Solution® (HMO D-SNP)
- Medica AccessAbility Solution® Enhanced (HMO D-SNP)

**PLEASE SIGN AND RETURN THIS FORM IN THE ENCLOSED ENVELOPE.**

\_\_\_\_\_  
 Applicant Signature  
 (Or signature of legally authorized representative\*)

\_\_\_\_\_  
 Today's Date

\*The person authorized to act on your behalf under the laws of the State where you live.

### REASON FOR CANCELLATION:

(Please check one)

- Dissatisfaction with the health plan
- Moved from the service area
- Did not understand plan
- Spend-down
- Loyalty to physician
- Other - Please explain: \_\_\_\_\_

Please return to: SPP Enrollment  
 CW195  
 P.O. Box 9310  
 Minneapolis, MN 55440-9310