Medica

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
- ❑ Did not understand plan
- ❑ Loyalty to physician
- ❑ Moved from the service area
- ❑ Spend-down
- ❑ Other - Please explain: _____

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