PRAM INSURANCE SERVICES, INC.

Termination of Benefits Request Form

Name: ______________________________ **Member ID**: ____________________

In order to avoid any delay in processing your request, PLEASE COMPLETE THIS FORM IN ITS ENTIRETY.

☐ Cancel my entire prescription drug plan administered by PRAM insurance Services, Inc.

☐ Please remove only the dependents listed below from my prescription drug plan.

☐ Spouse/Domestic Partner: ____________________________
(Spouse Name)

☐ Dependent: ____________________________
(Dependent Name)

☐ Dependent: ____________________________
(Dependent Name)

☐ Dependent: ____________________________
(Dependent Name)

Requested Termination Date: ________________ If requested termination date is prior to the end of the paid billing cycle, the termination date will be the last day of the paid billling cycle. (Example: If requested date is the 15th of the month and the end of the paid billing cycle is the 31st of that month, the termination date will be the 31st of that month.)

Reason for terminating coverage:

☐ Other Coverage

☐ Medicare Eligible

☐ Other: ____

Member Signature: ____________________________________ **Date**: ________________

Return completed form to PRAM Insurance Services, Inc. at:

Fax: 714-475-3589 Email: memberterms@pram.com

Mail to: PRAM Insurance Services, Inc.
1 Pointe Dr., Suite 120
Brea, CA 92821
Attn: Member Terminations