



Group Termination Form

Oxford Health Plans (NY), Inc. ▪ Oxford Health Insurance Inc.

Mailing Address: P.O. Box 29142, Hot Springs, AR 71903

I. GROUP IDENTIFICATION

1. Group name

2. Group number:

Important Information

- Please submit your termination request 30 days prior to the date you wish to terminate.
- Please refer to your Group Enrollment Agreement (GEA) for details on terminating your group's policy.
- If you have questions regarding this form, please contact your Dedicated Group Service Team.

3. Requested date of Group termination:

4. Reason for Termination: Benefits Rates Service Other _____

Signature Date Title

Please Note: In order to execute a group termination request, a signature from an authorized person is required. Signature must be from the President, Owner, Current BA, Vice President, Director, Executive Officer or other high official at the group.