REQUEST FOR TERMINATION OF PREMIUM HOSPITAL AND/OR SUPPLEMENTARY MEDICAL INSURANCE

DO NOT WRITE IN THIS SPACE

The completion of this form is needed to document your voluntary request for termination of Medicare coverage as permitted under the Code of Federal Regulations.

Section 1838(b) and 1818A(c)(2)(B) of the Social Security Act require filing of notice advising the Administration when termination of Medicare coverage is requested. While you are not required to give your reasons for requesting termination, the information given will be used to document your

understanding of the effects of your request.				
NAME OF ENROLLEE (Please Print)		MEDICARE CLAIM NUMBER		
NAME OF PERSON, IF OTHER THAN ENROLLEE, WHO IS EXECUTING THIS REQUEST.	THIS IS A REQUEST FOR TERMINATION OF HOSPITAL INSURANCE MEDICAL INSURANCE	DATE SUPPLEMI MEDICAL INSUR WILL END		DATE HOSITAL INSURANCE WILL END
I request termination of my enrollment under	the above section(s) of	title XVIII of th	e Social	Security Act, as
amended, for the reason(s) stated below:				
LUNDEDOTAND THAT IS LAW DECLUDED TO DAY FOR MY HOORIT	AL INCUIDANCE THE TERMINATIO	V 05 MV 011PD1 5M5	NTARY MER	NOAL INQUIDANCE COVERAGE
I UNDERSTAND THAT IF I AM REQUIRED TO PAY FOR MY HOSPIT. WILL ALSO END MY HOSPITAL INSURANCE COVERAGE. According unless it displays a valid OMB control number. The valid OMB control number is estimated to average 25 minutes per response, including the time to review tion collection. If you have any comments concerning the accuracy of the € 7500 Security Boulevard, Baltimore, Maryland 21244-1850.	ng to the Paperwork Reduction Act of mber for this information collection is 0 w instructions, search existing data res	1995, no persons are r 1938-0025. The time re ources, gather the data	required to res equired to com a needed, and	spond to a collection of information inplete this information collection is complete and review the informa-
If this request has been signed by mark (X), two witnesses who know the applicant must sign below, giving their full addresses.	SIGNATURE (Write in Ink,			
1. NAME OF WITNESS	SIGN HERE			
ADDRESS (Number and Street, City, State and Zip Code)	MAILING ADDRESS (Num	ber and Street)		
2. NAME OF WITNESS	CITY, STATE, ZIP CODE			
ADDRESS (Number and Street, City, State and Zip Code)	DATE (Month, Day and Ye	ear)	TELEPHO	ONE NUMBER