Form Approved OMB No. 0938-0025 (Expires: TBD)

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.

for requesting termination, the information given of the effects of your request.	will be used to document you	ur understanding		
NAME OF ENROLLEE (Please Print)		MEDICARE NUMBER		
	True is a province con	D ATE CURRENT	4 D) (DATE HOSDITAL INSUDANCE
NAME OF PERSON, IF OTHER THAN ENROLLEE, WHO IS EXECUTING THIS REQUEST.	THIS IS A REQUEST FOR TERMINATION OF	DATE SUPPLEMENTARY MEDICAL INSURANCE WILL END WILL END		DATE HOSPITAL INSURANCE WILL END
	☐ HOSPITAL INSURANCE			
	☐ MEDICAL INSURANCE			
I request termination of my enrollment under the stated below:	above sections of title XVIII o	of the Social Security	Act, as amen	ded, for the reason(s)
I UNDERSTAND THAT IF I AM REQUIRED TO PAY FO INSURANCE COVERAGE WILL ALSO END MY HOSP		THE TERMINATION	OF MY SUPPLI	EMENTARY MEDICAL
If this request has been signed by mark (X), two witnesses who know the		SIGNATURE (Write in Ink)		
applicant must sign below, giving their full addresses. 1. NAME OF WITNESS		SIGN		
		HERE		
ADDRESS (Number and Street, City, State and Zip Code)		MAILING ADDRESS (Number and Street)		
2. NAME OF WITNESS		CITY, STATE, ZIP CODE		
ADDRESS (Number and Street, City, State and Zip C	Code)	DATE (Month, Day	and Year)	TELEPHONE NUMBER

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0025. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.