DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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.

NAME OF ENROLLEE *(Please Print)*		MEDICARE 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 ~~SUPPLEMENTARY MEDICAL INSURANCE~~ WILL END	DATE ~~HOSPITAL INSURANCE~~ WILL END

I request termination of my enrollment under the above sections of title XVIII of the Social Security Act, as amended, for the reason(s) stated below:

I UNDERSTAND THAT IF I AM REQUIRED TO PAY FOR MY HOSPITAL INSURANCE, THE TERMINATION OF MY ~~SUPPLEMENTARY MEDICAL INSURANCE~~ COVERAGE WILL ALSO END MY ~~HOSPITAL INSURANCE~~ COVERAGE.

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)* **SIGN HERE**	
1. NAME OF WITNESS		
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 Code)*	**DATE** *(Month, Day and Year)*	**TELEPHONE NUMBER**