Discontinuation of Sedera Health Membership

This form must be completed when a member is discontinuing their membership in Sedera Health, whether due to termination of employment or a request to withdraw their membership. **As per the Services Agreement, Client agrees to notify us within 5 days of event.**

Member Name: _____
Group Name: _____
Internal Sedera Facilitator Name:
_____
Discontinuation Effective Date (must be last day of the month):
_____

Please check the box below to indicate the reason for discontinuation of benefits:

- ❑ Member is no longer employed with organization
- ❑ Member is not interested in renewing their membership
- ❑ Member is joining spouse or parents' insurance offered through their employment
- ❑ Member is dissatisfied with Sedera Health membership (program did not meet member's expectations)
- ❑ Member is dissatisfied with Sedera Health's customer service (issues not resolved to member's expectations)
- ❑ Other (Please explain)

  _____

Note: *Please note members affiliated with an Employer who are terminating membership will not be able to re-enroll until Employer's next open-enrollment period. The applicant will need to complete a new Membership Application and will be treated as a new member; therefore, any existing medical conditions will be treated as pre-existing conditions and be subject to the restrictions stated in the Membership guidelines.*

Additional Notes/Comments: _____
_____

Signature of Primary Member: _____ Date: _____

Signature of Internal Sedera Facilitator: _____ Date: _____

How could Sedera Health improve their product and/or how they serve their members?

_____
_____