Membership Cancellation Request

Please submit this form to request a membership cancellation for your entire household.

SECTION A

Membership Information

PRIMARY CONTACT

FIRST NAME

LAST NAME

MEMBER ID#

PHONE

EMAIL

SECTION B

Reason for Canceling

Check All that Apply

- ☐ **CANNOT ABIDE BY STATEMENT OF STANDARDS**
- ☐ **FINANCIAL HARDSHIP**
- ☐ **NOT SATISFIED WITH MEMBERSHIP OFFERINGS**
- ☐ **NOT SATISFIED WITH CUSTOMER SERVICE**
- ☐ **OTHER HEALTH CARE SHARING ORGANIZATION**
- ☐ **PROVIDER DOES NOT ACCEPT ALTRUA HEALTHSHARE**

If Enrolled by an Independent Member Representative (IMR)

- ☐ **MISINFORMED**
- ☐ **NOT AUTHORIZED**

Other Insurance

- ☐ **TRADITIONAL INSURANCE**
- ☐ **MEDICARE/MEDICAID**
- ☐ **EMPLOYER HEALTH COVERAGE**

*This form must be received by the 25th day of the month for the cancellation to go into effect on the 1st day of the following month. Contributions will be processed until the cancellation goes into effect.

Please submit this form by email, fax or mail.

SECTION C

Cancellation Date

- ◯ **CANCEL MY MEMBERSHIP AT THE END OF THIS MONTH**
  (This form must be received by the 25th.*)
- ◯ **CANCEL MY MEMBERSHIP AT THE END OF THE MONTH OF** _____

SECTION D

Written Request

Please provide a detailed explanation of the reason for your cancellation request.

Please Sign

PRIMARY CONTACT SIGNATURE

PRIMARY CONTACT NAME **DATE**

EMAIL MEMBERFORMS@ALTRUAHEALTHSHARE.ORG | **PHONE** 1.833.325.8782 | **FAX** 512.382.5520 | **MAIL** PO BOX 90849, AUSTIN, TX 78709-0849

Caring for One Another