Disenrollment Form

Please sign this form and return it to the Medical Associates Health Plans office in the enclosed envelope as soon as possible.

I hereby verify that I would like to cancel my Medical Associates Health Plans coverage effective______________________

________________________________	____________________________
Name	ID Number
________________________________	____________________________
Signature	Date

PLEASE NOTE: This disenrollment form needs to be received by MAHP by the last business day of the month to be disenrolled for the following month. You may also request a future disenrollment date, but no more than 3 months in advance.

Medical Associates Health Plans
1605 Associates Drive
Dubuque, IA 52002
Phone: 563-584-4885 or 1-866-821-1365
Fax: 563-556-5134
Email: memberservices@mahealthcare.com