Membership Cancellation Form

We are sorry to lose you as a patient and hope you had a great experience with Paladina Health.
To cancel the Membership Agreement for you and your dependents, you must complete this form or contact Paladina Health Member Services. If you change your mind, it's easy to join Paladina Health again. Contact Paladina Health Member Services at 1-866-808-6005 or email MemberServices@paladinahealth.com for more information.

Please submit signed membership cancellation forms to Paladina Health Member Services via fax (1-888-972-1735) or mail: Paladina Health Member Services, 1400 Wewatta Street, Suite 350, Denver, CO 80202.

Patient Information

Last Name:*	Legal First Name:*	M.I.:
Address:*		Apt#:
City:*	State:*	Zip:*
Date of Birth (mm/dd/yyyy):*	Phone: ☐ Mobile ☐ Home ☐ Work	
Email:*		

Dependent Information

① Last Name:*	Legal First Name:*
DOB* (mm/dd/yyyy):	Relationship:
② Last Name:*	Legal First Name:*
DOB* (mm/dd/yyyy):	Relationship:
③ Last Name:*	Legal First Name:*
DOB* (mm/dd/yyyy):	Relationship:

Membership Cancellation

Membership cancellation effective date: _____

The earliest effective cancellation date will be the date we receive this form. The date of termination shall be immediate unless otherwise requested. No refunds shall be made if you terminate this Membership Agreement as all fees paid are non-refundable.

I am canceling my Paladina Health membership because:

- ☐ Employment related reasons
- ☐ Inconvenient location
- ☐ Relocation
- ☐ Changing Provider
- ☐ Hours of Operation/Availability
- ☐ Dissatisfied with Membership
- ☐ Financial Considerations
- ☐ Other, please specify _____

Authorization

By signing below, I acknowledge that I am canceling my Paladina Health Membership Agreement for myself and any dependents listed in the Dependent Information section of this form. My dependents may be my spouse, partner or dependents for whom I am the legal parent, guardian or personal representative. I understand that my Paladina Health care team can help coordinate the transfer of my healthcare records to my selected provider or provide me a copy of my healthcare records. I acknowledge that once my membership is canceled, I will not be able to see a Paladina Health provider until I choose to join Paladina Health again.

Signature of Patient or Legal Guardian	Signed Date	Relationship to Patient
Print Patient's Name	Print Legal Guardian's Name (if applicable)	

*Required information

Membership Cancellation #1 (6-14-19)