DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

PLAN YEAR 2016 PLAN WITHDRAWAL NOTIFICATION FORM

Please: a. Fill in the fields below.

b. Electronically sign this form or print, sign, and scan the form.

c. Send the form to CMS_FEPS@cms.hhs.gov with the subject line: "QHP Plan Withdrawal Notice".

d. Remove withdrawn plans from data templates prior to data lockdown on August 25, 2015. If requesting to withdraw plans after August 25, 2015 do not remove plans from data templates.

This form provides information to the Centers for Medicare & Medicaid Services about Qualified Health Plan (QHP) or Stand-Alone Dental Plan (SADP) withdrawals requested by _____
(Issuer Legal Name)

Issuer _____ intends to withdraw the following Plan IDs (list all impacted Plan IDs in the table below):
(Issuer ID)

Plan IDs:

Reason(s) for withdrawal request:
In the space below, please indicate the reason for which you are requesting to withdraw the Plan IDs listed in the table above.

_____

Signature:

I, _____, confirm that the QHP(s) and/or SADP(s) listed above should be
(Name of Authorized Representative of Issuer)
withdrawn. I understand that these Plan IDs will not be offered in _____ for Plan Year 2016. I confirm that the
(State)
applicable state has been notified and that I am adhering to 45 CFR 156.290 and the requirements for product discontinuation under 45 CFR 147.106 when electing not to accept additional enrollees through the Marketplace.

_____ _____
(Signature) (Date)

_____ _____
(Print Name) (Title)