



CAGW HEALTH CARE PROGRAM

GROUP AUTHORIZATION- TERMINATION

MAY 1, 2008 – APRIL 30, 2009

Group Name			Contact Name		
If any of the information below has changed, please update.					
Billing Address			Title		
City	State	Zip	Telephone Number		
Contact's Email			Fax Number		

We elect to terminate our participation in the CAGW Healthcare Program effective (mm/yyyy) _____
 All participants are to be terminated from the policies they are enrolled in.

All policies and terminations become effective on the first day of the month.

Voluntary or involuntary termination from the CAGWHP, in full or in part, does not clear a CAGWHP member from an unpaid balance to CAGW, plus any applicable fees.

Signature _____ Date _____

Send this form and any additional materials to:

Attention: CAGW Healthcare

Mail: Cultural Alliance of Greater Washington
 1436 U Street, NW
 Suite 103
 Washington, DC 20009

Email: tparrott@cultural-alliance.org

Fax: 202-638-3388