Voluntary Group Disenrollment Form

Name:	
Medicare Number:	
Date of Birth:	
Sex:	
Home Phone Number:	
Member ID:	
Termination Date:	

Please terminate my coverage based on the information provided above.

Your Signature: _____ Date: _____

* Please note that termination dates are based on the signature date of the disenrollment request and can only be processed for a prospective date.

Please mail, fax, or email back to –

AETNA
PO BOX 818013
Cleveland, OH 44181-8013
Attn City of New York

Fax is (860) 907-3010, Attn Jennifer Robertson

Email is CONYmailbox@aetna.com