WEA trust
45 Nob Hill Road | Madison, Wisconsin 53713
800.279.4000 WEAtrust.com

WEA-MedPlus Health Plan Notice of Termination

WEA-MedPlus members must provide a notice of health plan termination when moving to a new health plan. Please complete the requested information, sign and date this form.

If you, the primary member (or subscriber) of the health plan, also have a spouse on the health plan, please complete their information as well.

Once you have completed the form, you can email it to **Eligibility@WEAtrust.com** or mail it to the following address:

WEA Trust
PO Box 21538
Eagan, MN 55121

PRIMARY MEMBER (SUBSCRIBER) INFORMATION	
Primary Member (Subscriber) Name:	**Primary Member (Subscriber) Date of Birth:**
Primary Member (Subscriber) ID Number:	**Requested Date of Termination (*month/date/year*):**

SPOUSE INFORMATION, IF APPLICABLE	
Spouse's Name (*if applicable*):	**Spouse's Date of Birth (*if applicable*):**
Spouse's ID Number (*if applicable*):	

_____ _____

Primary Member (Subscriber) Signature **Date**

_____ _____

Spouse's Signature **Date**