

Group Employee or Dependent Cancel Form



A. PERSONAL INFORMATION - Please print all information in black or blue ink.

Provide the group number:

_____ Health _____ Vision _____ Dental _____

Employee's last name _____ First name _____ M.I. _____

Subscriber Member ID number _____ Social Security number _____

Home phone _____ Work phone _____

Employee's home address:

Street _____

City _____ State _____ ZIP _____

B. SELECTION – Check appropriate boxes to cancel coverage

Type of coverage being canceled:

- Health Vision Dental
- Cancel all coverage (employee and dependents)
- Cancel all dependent coverage only
- Cancel coverage **only on the dependent(s)** listed below in section C

Reason for cancellation:

- Left employment
- Retired
- Reduction of work hours
- Employer contribution for coverage terminated
- Marriage
- Subscriber requested
- Death
- Group continuation (COBRA) period exhausted
- Divorce
- Other Reason _____

Date the reason for cancellation occurred _____

Note: Coverage costs can be credited up to two months retroactively from the date Blue Cross and Blue Shield of Minnesota received written notification of the cancellation.

Example: Notification received July 3 that John Doe left employment on April 1. John's coverage will be canceled effective June 1.

X Signature of employee/contractholder	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; font-size: small;">Month</td> <td style="text-align: center; font-size: small;">Day</td> <td style="text-align: center; font-size: small;">Year</td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> </table> Date signed	Month	Day	Year			
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