BlueCross BlueShield Minnesota

A. GROUP EMPLOYEE OR DEPENDENT CANCEL FORM - 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 ID#/Social Security Number	Home phone
				( )

Employee's Home address	Street	City	State	Zip code	Work phone
					( )

B. SELECTION – CHECK APPROPRIATE BOXES TO CANCEL COVERAGE

Type of coverage being cancelled:

☐ Health ☐ Vision ☐ Dental

☐ Cancel All Coverage (employee & 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
☐ Other
☐ Subscriber requested
☐ Death
☐ Group continuation (COBRA) period exhausted
☐ Divorce

Reason_____

Date of Event _____

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 3rd that John Doe left employment 04/01/xx. John will be cancelled effective 06/01/xx.

X	Month	Day	Year

Signature of employee — Date signed

C. LIST ALL INDIVIDUALS TO BE CANCELLED – COMPLETE ALL THAT APPLY (use extra paper if necessary)

Last name	First name	M.I.

This information is also available in other ways to people with disabilities by calling customer service at **1-800-382-2000** (toll free).

For TTY: Call 711

Hours: 8 a.m. to 6 p.m. Central Time, Monday through Friday

Attention: If you want free help translating this information, call the above number.
Atención: Si desea ayuda gratis para traducir esta información, llame al número que aparece arriba.

NOTE: Federal law and Minnesota law require that most group health plans give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

CANCEL FORM SHOULD BE SENT TO:

Blue Cross and Blue Shield of Minnesota
P.O. Box 982801
El Paso, TX
79998-2801
Fax: 651-662-7258
Email: enrollment.forms@bluecrossmn.com