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 occured ______________________

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	Month	Day	Year
Signature of employee/contractholder	Date signed		

C. LIST ALL INDIVIDUALS WHOSE COVERAGE IS BEING CANCELED – USE EXTRA PAPER IF NECESSARY

Last name	First name	M.I.

This information is also available in other formats for people with disabilities. Call 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.

Send this cancel form 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

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