BlueCross BlueShield Minnesota

INDIVIDUAL/FAMILY CANCEL FORM

NOTE: If you have coverage purchased through MNsure, you must contact MNsure to terminate the coverage and/or update changes.

Instructions: Please check the appropriate box and answer any questions. For prompt consideration, all cancel requests must include the contract holder's signature on the reverse side of this form.

If you need assistance, please call the customer service number located on your ID card.

Contract Holder's Identification Number _____ Group Number(s) _____

Contract Holder's Name_____Date of Birth _____
mm/dd/yyyy

Email Address_____

This cancel pertains to (request will be made to all checked coverage if applicable):

☐ Health Coverage ☐ Dental Coverage ☐ Vision Coverage

A. Cancellation of coverage for entire contract, including all covered dependents (if applicable).

FUTURE FIRST OF THE MONTH REQUESTED TERMINATION DATE _____
mm/yyyy

Reason: ☐ Medicare ☐ Other Insurance ☐ Active Duty Military ☐ Divorce ☐ Death ☐ Other _____

B. Deletion of Contract holder and continuation of coverage for dependents: Please check the reason and provide the event date. The effective date for the continuing dependents will coordinate with the term date of the contract holder.

☐ Death _____ ☐ Medicare _____ ☐ Divorce _____
mm/dd/yyyy mm/yyyy mm/yyyy

New Contract holder's name: _____ *Social Security Number: _____
(New contract holder must sign, in addition to the current contract holder, on the reverse side of this form)

Address if different from current address: _____

Dependents to retain coverage:
(Note: Dependents currently covered under the plan will be terminated if not listed below).

Name: _____ *Social Security Number: _____

Name: _____ *Social Security Number: _____

Name: _____ *Social Security Number: _____

Name: _____ *Social Security Number: _____

Name: _____ *Social Security Number: _____

Name: _____ *Social Security Number: _____

*Social Security Numbers (SSN) for you and your dependents are requested for benefit administration, however, not required.

Signature required – see reverse side – OVER

C. Cancel coverage for dependent(s)

Cancel coverage for the following dependents(s): _____
Name of dependent(s)

Future first of the month requested termination date: _____
mm/dd/yyyy

My signature on this Cancellation Form indicates that I am the Contract Holder and am authorized to cancel this coverage. I have read and fully understand the following statements when requesting cancellation of the listed individual contract with Blue Cross and Blue Shield of Minnesota and/or Blue Plus (Blue Cross).

I acknowledge that the coverage will be canceled on the first day of the month following receipt of this cancellation request unless a different termination date is required by law or regulation, a future effective date is selected above, or unless Premium is owed. If Premium is owed, Contract termination will be effective the first day of the month following the conclusion of the last period for which Premium was paid. In the instance of death, coverage will be cancelled effective at 12:01 a.m. the following day.

I understand and acknowledge that in cancelling the dental and/or vision plan coverage, I and/or any covered dependents will be unable to re-enroll in a Blue Cross dental and/or vision plan for three years from the date the coverage is cancelled, and will be subject to any applicable waiting periods before contract benefits become available.

If premium payments are made through automatic withdrawal, I understand and acknowledge that if this cancellation request is submitted within fifteen (15) days of my next payment, the next payment may occur and I will subsequently be reimbursed for any premium overpayment. Claims for services incurred after the date of cancellation will not be covered. If this form is completed as an electronic form, both parties agree to conduct this transaction electronically.

Print Name _____

Contract Holder's Signature X _____ Date _____
mm/dd/yyyy

Parent/Legal Guardian or Guarantor's Signature X _____ Date _____
(if contract holder is a minor) mm/dd/yyyy

Spouse/Domestic Partner/Dependent's Signature X _____ Date _____
(if coverage is being retained, new contract holder must sign) mm/dd/yyyy

Send to: Blue Cross and Blue Shield of Minnesota, P.O. Box 982801, El Paso, TX 79998
Fax to: 651-662-6439 Email to: Incoming.Service.Center@bluecrossmn.com

BlueCross BlueShield Minnesota

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒိး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိ်, ကိး 711 တကှ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta’e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d’assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį’ béésh bee hodíílnih.