



165 Court St, Rochester, NY 14647
 A nonprofit independent licensee of the BlueCross BlueShield Association

MEMBERSHIP CANCELLATION WORKSHEET

Do not use - Microfilm Use only

Employer Group Representative – Please complete information below.					
Group Name					
Group Representative Signature				Date Prepared (mm/dd/yy)	
Medical Group #	Chk. Digit	Dental Group #	Chk. Digit	Vision Group #	Chk. Digit

Please Note: If you are canceling an Employees or dependents coverage, the cancel date is a to date, not a through date. (i.e. cancel date July 30th coverage ends July 29th at midnight)

INSTRUCTIONS: If canceling an Employee, complete Sections A and B. If canceling an Employee's Spouse or Dependent Member, complete Sections A, B and C. A Member is a spouse or Qualified Dependent. Cancel Reasons are listed at the bottom of this form.

SUBSCRIBER / EMPLOYEE INFORMATION			Please Print			
1	A	<input type="checkbox"/> Cancel (Entire contract) - Employee <input type="checkbox"/> Cancel Spouse or Dependent Member	<input type="checkbox"/> (M)edical <input type="checkbox"/> (D)ental <input type="checkbox"/> (V)ision	Cancel Reason (See List Below)	Current Employee/ Subscriber ID #	Requested Cancellation Date (Dates = mm/dd/yy)
					If Reason Code SD or DM indicate, Date of Death ___/___/___	
	B	Subscriber/Employee Last Name		Subscriber/Employee First Name		
C	Spouse or Dependent Member Last Name (if different)		Spouse or Dependent Member - First Name		Spouse or Member Birthdate	
					(Dates = mm/dd/yy)	

SUBSCRIBER / EMPLOYEE INFORMATION			Please Print			
2	A	<input type="checkbox"/> Cancel (Entire contract) - Employee <input type="checkbox"/> Cancel Spouse or Dependent Member	<input type="checkbox"/> (M)edical <input type="checkbox"/> (D)ental <input type="checkbox"/> (V)ision	Cancel Reason (See List Below)	Current Employee/ Subscriber ID #	Requested Cancellation Date (Dates = mm/dd/yy)
					If Reason Code SD or DM indicate, Date of Death ___/___/___	
	B	Subscriber/Employee Last Name		Subscriber/Employee First Name		
C	Spouse or Dependent Member Last Name (if different)		Spouse or Dependent Member - First Name		Spouse or Member Birthdate	
					(Dates = mm/dd/yy)	

SUBSCRIBER / EMPLOYEE INFORMATION			Please Print			
3	A	<input type="checkbox"/> Cancel (Entire contract) - Employee <input type="checkbox"/> Cancel Spouse or Dependent Member	<input type="checkbox"/> (M)edical <input type="checkbox"/> (D)ental <input type="checkbox"/> (V)ision	Cancel Reason (See List Below)	Current Employee/ Subscriber ID #	Requested Cancellation Date (Dates = mm/dd/yy)
					If Reason Code SD or DM indicate, Date of Death ___/___/___	
	B	Subscriber/Employee Last Name		Subscriber/Employee First Name		
C	Spouse or Dependent Member Last Name (if different)		Spouse or Dependent Member - First Name		Spouse or Member Birthdate	
					(Dates = mm/dd/yy)	

Cancel Reasons - Subscriber/Employee LE – Left Employment PC – Preferred Care CP – Commercial Coverage SB – Spouse's BCBS Plan MC- Medicaid CD – Cobra Disabled Date CE – Cobra End Date	Cancel Reasons – Spouse or Dependent Member MA – Marriage DM – Deceased MR – Subscriber Request DV – Member Divorce OA – Dependent Overage MB – Cobra Begin Date
SD – Subscriber Deceased SR – Subscriber Request CB – Cobra Begin Date	