



REQUEST TO CANCEL INSURANCE Blue Cross Blue Shield

Please cancel my _____ Insurance (medical/dental)

Effective _____

Name _____

SS# _____

Signature

Date

Please note that open enrollment occurs August 1- October 1 of every year. You will not be eligible to re-enroll outside of open enrollment unless you have a change in family status or change/loss of other insurance coverage.

This form must be received in the Benefits Office at least 10 (ten) days before the beginning of the month you are requesting the cancellation to occur.

Please return form to the Benefits Office 920-7929 or 920-7810

Date Received in Benefits Office _____ Date changed in Munis _____
Date notification sent to BCBS _____