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# CANCELLATION AUTHORIZATION FORM (1)

**Return via fax to** 404-842-8040

BlueCross BlueShield of Georgia

**Group Name:** _____ **Group Number:** _____

**Completed By:** _____ **Page** _____ **of** _____

**Title:** _____ **Telephone:** _____ **Date:** _____

**Employee**

Member No. | Last Name | First Name | MI

Cancellation Effective Date

**Cancel employee?** ☐ YES ☐ NO **If yes →** **Coverage being Canceled** ☐ Medical ☐ Dental ☐ Life

**Please note: Canceling the employee's coverage will cancel coverage for ALL dependents.** Reason ☐ Date of Death _____ ☐ Left Employment ☐ Other Coverage

**Cancel all dependents?** ☐ YES ☐ NO **If NO, complete the following:**

| Dependent Name (First, MI, Last Name) | Cancellation Effective Date* | Coverage Being Canceled |
|---|---|---|
| | | ☐ Medical ☐ Dental ☐ Life |
| | | ☐ Medical ☐ Dental ☐ Life |
| | | ☐ Medical ☐ Dental ☐ Life |

**Employee signature required for dependent cancellation.** _____ (Employee Signature) _____ (Date)

**Employee**

Member No. | Last Name | First Name | MI

Cancellation Effective Date

**Cancel employee?** ☐ YES ☐ NO **If yes →** **Coverage being Canceled** ☐ Medical ☐ Dental ☐ Life

**Please note: Canceling the employee's coverage will cancel coverage for ALL dependents.** Reason ☐ Date of Death _____ ☐ Left Employment ☐ Other Coverage

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| | | ☐ Medical ☐ Dental ☐ Life |
| | | ☐ Medical ☐ Dental ☐ Life |

**Employee signature required for dependent cancellation.** _____ (Employee Signature) _____ (Date)

**Employee**

Member No. | Last Name | First Name | MI

Cancellation Effective Date

**Cancel employee?** ☐ YES ☐ NO **If yes →** **Coverage being Canceled** ☐ Medical ☐ Dental ☐ Life

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| | | ☐ Medical ☐ Dental ☐ Life |

**Employee signature required for dependent cancellation.** _____ (Employee Signature) _____ (Date)

**Employee**

Member No. | Last Name | First Name | MI

Cancellation Effective Date

**Cancel employee?** ☐ YES ☐ NO **If yes →** **Coverage being Canceled** ☐ Medical ☐ Dental ☐ Life

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| | | ☐ Medical ☐ Dental ☐ Life |
| | | ☐ Medical ☐ Dental ☐ Life |
| | | ☐ Medical ☐ Dental ☐ Life |

**Employee signature required for dependent cancellation.** _____ (Employee Signature) _____ (Date)

***The cancellation effective date is very important! It should be the specific date (Month, Day, Year) coverage is to terminate. Services incurred on or after the cancellation date will not be covered.***