Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah
2890 E. Cottonwood Parkway
PO Box 30270
Salt Lake City, Utah 84130-0270

REQUEST FOR CANCELLATION

Please print in black ink. Incomplete and/or illegible information may result in delayed processing. **The form must be signed and dated by the Authorized Group Administrator or it will be returned.**

SECTION 1 - GROUP INFORMATION

Group Number	Group Name

SECTION 2 - EMPLOYEE AND DEPENDENT CANCELLATION INFORMATION

Please complete each section below to remove an employee or his/her dependent(s) from coverage.			Enter the last date of coverage for this member. (Coverage termination dates will be the last day of the month).	*Check below if employee paid no premium for coverage after the cancellation effective date.	*Check below to verify that the employee does not have an expectation of coverage after the cancellation effective date.
Employee or Dependent Name	**Date of Birth**	**Reason**	**Termination Date**		
1.	(mm/dd/yyyy)		(mm/dd/yyyy)	☐	☐
2.	(mm/dd/yyyy)		(mm/dd/yyyy)	☐	☐
3.	(mm/dd/yyyy)		(mm/dd/yyyy)	☐	☐
4.	(mm/dd/yyyy)		(mm/dd/yyyy)	☐	☐
5.	(mm/dd/yyyy)		(mm/dd/yyyy)	☐	☐
6.	(mm/dd/yyyy)		(mm/dd/yyyy)	☐	☐

SECTION 3 – AUTHORIZED SIGNATURE

Print Name of Authorized Group Administrator	Signature of Authorized Group Administrator	Date
		(mm/dd/yyyy)

*** For each person listed, both boxes must be checked in order for Regence BlueCross BlueShield of Utah to cancel coverage with an effective date prior to the date that Regence BlueCross BlueShield of Utah receives this form. If both boxes are not checked, Regence BlueCross BlueShield of Utah will cancel coverage effective the last day of the month in which this form is received.**

Return this form to the Membership Administrator or Membership Administrative Team indicated on your bill.