BlueCross BlueShield BluePlus of Minnesota
Independent licensees of the Blue Cross and Blue Shield Association

MII Life

DELTA DENTAL®

A. SMALL GROUP EMPLOYEE OR DEPENDENT CANCEL FORM - Please print all information in black or blue ink.

Provide the **group and subgroup** numbers:

Health	Dental	Life	Short Term Disability	Long Term Disability
_ _ _ _ _ _ - _ _	_ _ _ _ _ _ - _ _	_ _ _ _ _ _ - _ _	_ _ _ _ _ _ - _ _	_ _ _ _ _ _ - _ _

Employee's Last name	First name	M.I.	Subscriber ID#/Social Security Number	Home phone
				( )

Employee's Home address	Street	City	State	Zip code	Work phone
					( )

B. LIST ALL INDIVIDUALS TO BE CANCELLED – COMPLETE ALL THAT APPLY (use extra paper if necessary)

Last name	First name	M.I.	Social Security #

C. SELECTION – CHECK APPROPRIATE BOXES TO CANCEL COVERAGE

Type of coverage being cancelled:

☐ Health ☐ Dental ☐ Life ☐ Short Term Disability ☐ Long Term Disability
☐ Cancel All Coverage (employee & dependents)
☐ Cancel All Dependent coverage only
☐ Cancel Coverage only on the dependent(s) listed above

Reason for cancellation:

☐ Left employment
☐ Retired
☐ Reduction of work hours
☐ Employer contribution for coverage terminated
☐ Marriage
☐ Other
☐ Subscriber requested
☐ Death
☐ Group continuation (COBRA) period exhausted
☐ Dependent no longer a full-time student
☐ Divorce
Reason _____

Date of Event _____

Note: Coverage costs can be credited up to **two** months retroactively from the date Blue Cross and Blue Shield of Minnesota received written notification of the cancellation.
Example: notification received July 3rd that John Doe left employment 04/01/xx. John will be cancelled effective 06/01/xx.

X	Month	Day	Year

Signature of employee — Date signed

D. THIS SECTION TO BE COMPLETED BY EMPLOYER

I certify the above information to be true and correct.

Employer Signature _____ Date _____

Employer name	Telephone number	Fax number

NOTE: Federal law and Minnesota law require that most group health plans give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

F8708R01 (12/06)

CANCEL FORM SHOULD BE SENT TO:

Blue Cross and Blue Shield of Minnesota and Blue Plus
P.O. Box 64024
St. Paul, Minnesota
55164-0024
Fax: 651-662-7258