BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association.

NOTICE OF COVERAGE TERMINATION

Date: _____

Group Name: _____ Group Number: _____

Whenever an employee/dependent terminates coverage from your group plan, please complete the information requested below and send it to us so that we can provide the employee/dependent with a Certificate of Health Coverage. Please fax or send this information to:

Blue Cross and Blue Shield of Nebraska
Attn. Membership Department
P.O. Box 3248
Omaha, NE 68180-0001
Fax: (402) 343-3308

Terminating Subscriber/Dependent Name	I.D. Number	Date of Coverage Termination	Termination Reason Code

Please indicate reason code for termination:

1) left employment
2) deceased
3) employee requests cancellation
4) terminate ineligible dependent
5) other - please explain

*If terminated employee provides a corrected address, please attach documentation of new address.

SIGNATURE: _____