BlueCross BlueShield Nebraska

Cancellation Request

PO Box 3248
Omaha, NE 68180-0001
Fax: (402) 548-4685
Email to: IndContractInstallation@nebraskablue.com

Member ID: _____ Date: _____

Your Name (please print): _____ Phone: _____

Please check the appropriate boxes:

Insurance type: ☐ Health ☐ Dental
Request type: ☐ Cancel policy ☐ Remove dependent(s)

If removing dependents, please provide first and last names below:

_____ _____

_____ _____

_____ _____

Reason for cancellation:

_____

The cancellation will be effective a) the last day of the month this form is received, **OR** b) the termination date noted below. Coverage cannot be terminated earlier than the date this form is received by Blue Cross and Blue Shield of Nebraska. Dependents cannot be terminated earlier than the last day of the month this form is received.

If cancelling your policy, requested cancellation date: _____

If removing dependent(s), requested cancellation date: _____

Note: This form **MUST** be signed by the member for the cancellation to be effective. The member is the individual who is named on the identification card. For a "Child-Only" plan, the member is the parent or guardian identified in Blue Cross and Blue Shield of Nebraska's records. We will not cancel coverage if this form is signed by anyone other than the member.

All refunds will be returned via check to the address on file. Refunds can take up to 4-6 weeks to be mailed.

If you need assistance or have questions, please call the Member Services number on the back of your ID card.

Member Signature _____ Date _____