Cancellation Request Form

BlueCross BlueShield Nebraska

P.O. Box 3248
Omaha, NE 68180-001
Fax: 402-548-4685
Email: IndContractInstallation@NebraskaBlue.com

Member ID: _____ Date: _____

Member Name (please print): _____ Phone #: _____

Please choose appropriate boxes: (if canceling more than one type of insurance, please select all that apply)

Request type: ☐ Cancel policy ☐ Remove dependent(s)

Insurance type: ☐ Armor Health* ☐ Medicare Supplement ☐ Dental

If removing dependents, please provide first and last names below. Dependents cannot be terminated earlier than the last day of the month this form is received.

_____ _____

_____ _____

_____ _____

Reason for cancellation:

_____

Cancellation for Medicare Supplement and Dental policies 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. Please confirm your requested cancellation date below. If no date is specified, termination will be effective the last day of the month this form is received.

If canceling a Medicare Supplement or Dental policy, requested cancellation date: _____

***Please note: Cancellation for Armor Health policies will be effective the last day of the month this form is received.**

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.

Any refunds due will be sent within 4-6 weeks of processing the requested cancellation via check, to the member's address on file.

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

Member Signature: _____ Date: _____