

NOTICE OF COVERAGE TERMINATION

A Not-For-Profit Mutual Insurance Company and an Independent Licensee of the Blue Cross and Blue Shield Association.

Date:			
Group Name:	Group Number:		
Whenever an employee/dependent ter complete the information requested be employee/dependent with a Certificate information to:	low and send it to us	so that we can prov	vide the
Blue Cross a	lembership Departme and Blue Shield of No P.O. Box 3248 aha, NE 68180-0001 ax: (402) 343-3308	ent ebraska	
Terminating Subscriber/Dependent Name	I.D. Number	Date of Coverage Termination	Termination Reason Cod
Please indicate reason code for termin	ation:		
1) left employment			
2) deceased			
3) employee requests cancellation	n		
4) terminate ineligible dependent			
5) other - please explain			
If the employee provides a corrected address, please attach documentation of new address.			
SIGNATURE:			