Cancellation Authorization Form (2)

Return via fax to 888-470-6598

BlueCross BlueShield of Georgia | BlueCross BlueShield Healthcare Plan of Georgia | Greater Georgia Life Insurance Company

EMPLOYER/GROUP USE ONLY		
Group name	Lumenos plan information	
Group no.	Sub-section	Case no.
Completed by		No. of pages
Title	Phone no.	Date (MM/DD/YYYY)

EMPLOYEE INFORMATION Services incurred on or after the cancellation date will not be covered.

Social security no.	Last name	First name	M.I.

Cancel employee ☐ Yes ☐ No
If yes, cancellation effective date: (MM/DD/YYYY) ____/____/____
Note: Cancelling the employee's coverage will cancel coverage for ALL dependents.
CANCEL all dependents? ☐ Yes ☐ No If no, complete the following:

Coverage being cancelled:
☐ Medical ☐ Dental ☐ Life ☐ Vision ☐ EAP ☐ STD ☐ Other________
Reason:
☐ Left Employment ☐ Other Coverage ☐ Death Date of Death (MM/DD/YYYY)____/____/____

Dependent last name	Dependent first name	M.I.	Cancellation date (MM/DD/YYYY)	Coverage being cancelled
				☐ Medical ☐ Dental ☐ Life ☐ Vision ☐ Other
				☐ Medical ☐ Dental ☐ Life ☐ Vision ☐ Other
				☐ Medical ☐ Dental ☐ Life ☐ Vision ☐ Other

Employee signature required for dependent cancellation
Signature **X** Date (MM/DD/YYYY)

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