Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.

BLUE CROSS & BLUE SHIELD OF MISSISSIPPI REQUEST TO CANCEL EMPLOYEE INSURANCE COVERAGE

Please fax this form to (601) 664-4093 (ATTN: Enrollment Control Center) or mail to:

Enrollment Department
P. O. Box 1043
Jackson, MS 39215-1043

Group Name: ______________________________

**** It is important that you submit employee terminations to us as soon as possible so we can update our records timely****

How to Use this Form
To terminate an employee's coverage due to the employee leaving employment or due to the death of the employee, complete the form below and fax or mail to the above number or address. If the employee has more than one type of coverage to be terminated (health, dental, life) please include all ID numbers. Please include all pertinent information below and the printed and signed name of the person submitting this information on behalf of the group.

Note: Do not use this form for any voluntary employee request to cancel coverage. If the employee requests to cancel coverage, the employee must fill out and sign a Request for Change Form (BCBS 16520) which must be mailed to the address noted above.

Note: Blue Cross & Blue Shield of Mississippi will depend on the accuracy of the information submitted by you on this form. We will not be responsible for any employee coverage issues which arise as a result of inaccurate information submitted to us by the group.

Group#	Employee ID (as shown on group's invoice)	Employee Name	Termination Date of Employment (Due to reason shown at right)	Reason Code 1 – Left Employment 2 – Deceased (write date of death at right)

Date	Name of Person Submitting on Behalf of the Group	Signature of Person Submitting on Behalf of the Group	Phone Number

BCBS 14767 Rev. 1/04