BlueCross BlueShield of Wyoming
An independent licensee of the Blue Cross and Blue Shield Association.

Request to Cancel Dependent Coverage

4000 House Avenue
P. O. Box 2266
Cheyenne, WY 82003
307.634.1393
1.800.442.2376

YOUR NAME _____ Date cancellation is to become effective _____

SOCIAL SECURITY NUMBER _____ IDENTIFICATION NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SIGNATURE _____ DATE SIGNED _____

NOTE: I have read and understand the evidence of insurability requirements and/or late enrollee limitations of my Group Master Agreement or Plan document and realize that if I decide to add these dependents at a later date, they will be subject to these provisions as permitted by applicable law.

Please check below the relationship of dependent(s):

❑ Husband ❑ Wife ❑ Son ❑ Daughter ❑ Other _____

Reason for deleting dependent(s) from coverage:

❑ Divorce _____ (MM/DD/YY) ❑ Separation _____ (MM/DD/YY) ❑ Death _____ (MM/DD/YY) ❑ Receiving coverage elsewhere

❑ Child no longer eligible for coverage because:

❑ Attained limiting age ❑ No longer full-time student (give last date of full time attendance) _____ (MM/DD/YY) ❑ Married (please give date of marriage) _____ (MM/DD/YY)

❑ Other (please explain) _____

PRINT FIRST NAME AND INITIAL (INCLUDE LAST NAME IF DIFFERENT)	BIRTHDATE (MO/DAY/YR)
Delete 1.	
Delete 2.	
Delete 3.	
Delete 4.	

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