WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

Request for Cancellation

Effective Date Requested: _____

Please cancel my Blue Cross Blue Shield of Wyoming coverage.

Print Name: _____ ID Number: _____

Reason for Cancellation: _____

_____

Cancellation requests must reach the Blue Cross Blue Shield office before the first of the month of the requested cancellation date, and **must be signed** by the subscriber.

_____ _____ _____

Signature Telephone Date

If your healthcare coverage is through your work, please submit this form to your employer. Otherwise, please submit it to:

Blue Cross Blue Shield of Wyoming
P O Box 2266; Cheyenne, WY 82003
Phone: 800.442.2376
Fax: 307.634.5742