BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

HMO Louisiana, Inc.

A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

COVERAGE CANCELLATION

GROUP NAME	GROUP NUMBER

Coverage with Blue Cross and Blue Shield of Louisiana will terminate on the following employees:

EMPLOYEE'S NAME	CONTRACT NUMBER
EMPLOYEE'S ADDRESS	
LAST DATE OF EMPLOYMENT	

EMPLOYEE'S NAME	CONTRACT NUMBER
EMPLOYEE'S ADDRESS	
LAST DATE OF EMPLOYMENT	

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LAST DATE OF EMPLOYMENT	

By submitting a request to cancel any individual's coverage on this form, the Group/Employer/Company states:

❑ That neither the Member nor his/her dependent being cancelled has made any payment towards the cost of any premium (whether through payroll deductions or otherwise, or whether total or partial) for any period beyond the date the Group/Employer/Company, etc. is requesting the coverage to be terminated. The exception is employee contributions toward the cost of family coverage when termination of a dependent does not affect the total cost of the employee premium for a period after the date the cancellation is being requested.

❑ That no information was provided or representation made to the Member or his/her dependent being cancelled that would create an expectation that the individual's coverage would continue beyond the date of the requested coverage termination, except for legally required disclosures regarding rights to COBRA or other mandated form of continuation coverage.

X ______________________________ ______________

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF THE GROUP DATE

Please fax this form to (225) 298-2988 or mail to:

Blue Cross and Blue Shield of Louisiana
Attention: Membership and Billing Department
P. O. Box 98029
Baton Rouge, LA 70898-9029