WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

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

Request to Cancel Dependent Coverage

YOUR NAME ______________________ Date cancellation is to become effective ______________________

SOCIAL SECURITY NUMBER ______________________ **ID NUMBER** ______________________

ADDRESS ______________________ **CITY** ______________ STATE ________ ZIP ________

☐ Check here if address is different.

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/YYYY) ☐ Separation ____________ (MM/DD/YYYY) ☐ Death ____________ (MM/DD/YYYY) ☐ Receiving coverage elsewhere

☐ Child no longer eligible for coverage because:

☐ No longer full-time student (give last date of full time attendance) ______________________ (MM/DD/YYYY)

☐ By Request

☐ Other (please explain) ______________________

	PRINT FIRST NAME & INITIAL (INCLUDE LAST NAME IF DIFFERENT)	BIRTHDATE (MM/DD/YYYY)
Delete 1.		
Delete 2.		
Delete 3.		
Delete 4.		

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