599 Empress St., P.O.Box 1046, Winnipeg, Manitoba R3C 2X7

CANCELLATION REQUEST
DUE TO OTHER COVERAGE

Re: ______________________ ______________ ______________

MANITOBA BLUE CROSS SUBSCRIBER | CONTRACT NUMBER | GROUP NO.

I am requesting to cancel the following benefits (check plans to be cancelled):

- ☐ Extended Health
- ☐ Dental
- ☐ Travel
- ☐ Vision

Manitoba Blue Cross Subscriber's Signature: ______________________

Personnel Administrator's Signature: ______________________

Date: ______________________

THIS PORTION IS TO BE COMPLETED BY OTHER EMPLOYER/INSURER

Name of Insurer* ______________________________________

*(*If insurer is Manitoba Blue Cross, Contract # and Group # are sufficient).*

Contract # ____________________ Group # ____________________

Type of Coverage ______________________________________

____

List persons insured and the effective date of the above group policy:

NAME	EFFECTIVE DATE OF COVERAGE

Other Insurer/Employer Signature: ______________________

Telephone Number: ______________________

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