MANITOBA BLUE CROSS®

CANCELLATION REQUEST DUE TO SPOUSAL COVERAGE FORM

Employee's Name: _____ Contract Number: _____ Group Number: _____

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

☐ Extended Health ☐ Travel
☐ Dental ☐ Vision

Manitoba Blue Cross Subscriber's Signature: _____
Personnel Administrator's Signature: _____
Date: _____

This portion is to be completed by spouse's employer / insurance company

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 of insured	Effective date of coverage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Spouse's Employer / Insurer Name: _____

Spouse's Employer / Insurer Signature: _____

Phone Number: _____