

## **CANCELLATION REQUEST DUE TO SPOUSAL COVERAGE FORM**

лоуее s магне:	Contract Numb	er:	Group Number:
I am requesting to ca	ncel the following benefit	s (check plans to	be cancelled):
Extend Dental	led Health	Travel Vision	
Manitoba Blue Cross Subsci Personnel Administr	_		
This portion is to be	completed by spouse's	s employer/in	surance company
lame of Insurer*			
*If insurer is Manitoba Blue Cross	s, Contract # and Group # ai	re sufficient)	
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Contract #	Oroup #_		
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ist persons insured and the alame of insured	effective date of the above Ef	re group policy: fective date of o	coverage
ist persons insured and the clame of insured  Spouse's Employer/Insured	effective date of the above Ef	re group policy: fective date of o	coverage

<sup>®</sup> The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to the Manitoba Blue Cross Plan.