



**BlueCross BlueShield
of Louisiana**

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

COVERAGE CANCELLATION

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

EMPLOYEE'S NAME	CONTRACT NUMBER
EMPLOYEE'S ADDRESS	
TERMINATION DATE	

EMPLOYEE'S NAME	CONTRACT NUMBER
EMPLOYEE'S ADDRESS	
TERMINATION DATE	

EMPLOYEE'S NAME	CONTRACT NUMBER
EMPLOYEE'S ADDRESS	
TERMINATION DATE	

EMPLOYEE'S NAME	CONTRACT NUMBER
EMPLOYEE'S ADDRESS	
TERMINATION DATE	

X _____ DATE

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF THE GROUP

Please fax this form to (225) 297-2622 or mail to:

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