REQUEST TO CANCEL INSURANCE
Blue Cross Blue Shield

Please cancel my ☐ medical insurance ☐ dental insurance ☐ vision insurance

Effective _____

Name_____

MUNIS ID_____

_____ _____
Signature Date

Please note that cancellation will be effective the 1st day of the following month in which this request is received. If the form is received on the 1st, cancellation will be effective that date.

Please return form to the Benefits Office 920-7929 or 920-7810

Benefits Use Only:

Date Received in Benefits Office_____
Date changed in MUNIS _____
Date notification sent to BCBS_____