

# 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	

**X** \_\_\_\_\_  
SIGNATURE OF AUTHORIZED REPRESENTATIVE OF THE GROUP

\_\_\_\_\_  
DATE

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**