MANITOBA BLUE CROSS®

PROVINCE OF MANITOBA
CANCELLATION REQUEST DUE TO SPOUSAL COVERAGE

A request to cancel voluntary coverage must follow a recent life event and completion of this form within 60 days.

Employee's Name: _____

Contract Number: _____ Group Number: _____

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

☐ Extended Health ☐ Employee Travel Health

Manitoba Blue Cross Subscriber's Signature: _____

Pay and Benefits Consultant's Signature: _____

Date: _____

THIS PORTION IS TO BE COMPLETED BY SPOUSE'S EMPLOYER/INSURER

Name of Insurer:* _____
*(*If insurer is Manitoba Blue Cross, Contract Number and Group Number are sufficient).*

Contract Number: _____ Group Number: _____

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 Name Signature: _____

Phone Number: _____