MANITOBA BLUE CROSS®

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# PROVINCE OF MANITOBA

## CANCELLATION REQUEST DUE TO SPOUSAL/ALTERNATE GROUP COVERAGE

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

| EMPLYEE"S NAME | | EMPLOYEE NUMBER |
|---|---|---|
| CERTIFICATE NUMBER | CLIENT NUMBER | |
| I am requesting to cancel the following benefits (check plans to be cancelled): ☐ Ambulance Hospital ☐ Extended Health ☐ Travel | | |
| Manitoba Blue Cross Member's Signature | Benefit Administrator's Signature: | Date: (dd/mm/yyyy) |

**THIS PORTION IS TO BE COMPLETED BY ALTERNATE GROUP INSURANCE PROVIDER**

| Name of Insurer* (*If insurer is Manitoba Blue Cross, Certificate Number and Client Number are sufficient). | |
|---|---|
| Name of Employer | |
| Certificate Number | Client/Policy Number |
| Type of Coverage | |
| List persons insured and the effective date of the above group policy: | |
| Name | Effective Date of Coverage (dd/mm/yyyy) |
| | |
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| | |
| | |
| Alternate Insurer/Employer Name (Please print) | Alternate Insurer/Employer Signature |
| Telephone Number | |

**To protect the viability of the plans, you may not be able to opt back into the plans in the future. Please refer to your benefits guide or contact Manitoba Blue Cross for more information.**