MANITOBA BLUE CROSS®

599 Empress St. PO Box 1046, Stn Main Winnipeg MB R3C 2X7

CANCELLATION REQUEST
DUE TO ALTERNATE GROUP COVERAGE

Re: _____ _____ _____
MANITOBA BLUE CROSS SUBSCRIBER CONTRACT NUMBER GROUP NUMBER

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

☐ Extended Health ☐ Dental

Manitoba Blue Cross Subscriber's Signature: _____

Benefit Administrator's Signature: _____

Date: _____

THIS PORTION IS TO BE COMPLETED BY ALTERNATE GROUP INSURANCE PROVIDER

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

Contract # _____ Group # _____

Type of Coverage

_____ _____

_____

List persons insured and the effective date of the above group policy:

Name	**Effective Date of Coverage**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Spouse's Insurer/Employer Signature: _____

Telephone Number: _____