LOSS OF COVERAGE FORM

Re: _____ _____
Manitoba Blue Cross Applicant's Name — Employer Name

THIS PORTION IS TO BE COMPLETED BY SPOUSES'S EMPLOYER / INSURANCE CO.

This is to advise that _____ had coverage
name

through _____. This coverage was for
name of insurance company

_____ at a _____status.
type of coverage, health vision, dental — single/family

These benefits were cancelled as of _____.
date

Signature _____ Date _____
Representative

Must be returned within 90 days of loss of other coverage

MANITOBA BLUE CROSS APPRECIATES YOUR CO-OPERATION IN PROVIDING THIS INFORMATION