MANITOBA BLUE CROSS®

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

CANCELLATION REQUEST
DUE TO SPOUSAL/ALTERNATE GROUP COVERAGE

Re: _____ _____ _____
MANITOBA BLUE CROSS MEMBER | CERTIFICATE NUMBER | CLIENT NUMBER

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

☐ Extended Health ☐ Dental

Manitoba Blue Cross Member'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, Certificate # and Client # are sufficient).*

Name of Employer _____

Certificate # _____ Client/Policy # _____

Type of Coverage _____

_____

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

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

Alternate Insurer/Employer Name (Please Print)_____

Alternate Insurer/Employer Signature: _____

Telephone Number: _____