MANITOBA BLUE CROSS®

LOSS OF COVERAGE FORM

Employee's Name _____ Group Name _____

This portion is to be completed by spouse's employer/insurance company

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

Spouse's Employer/Insurer Name: _____

Spouse's Employer/Insurer Signature: _____

Phone Number: _____

Must be returned within 90 days of loss of other coverage