



Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

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# EMPLOYEE CANCELLATION FORM

**THIS SECTION TO BE COMPLETED BY THE GROUP ADMINISTRATOR**

Group Number	Group Name	Telephone Number	Regence BlueShield Use Only		
GROUP ADMINISTRATOR SIGNATURE X		Date	Date Received	Date Completed	Operator Initials

**GROUP INSTRUCTIONS**

1. This form is to cancel employees only. To cancel dependents, employees must complete an Employee Enrollment/Change Form.
2. Forms must be received by the 10th of the month in order to be excluded from the next month's billing.
3. Forms MUST INCLUDE the Group Administrator's signature.

**CANCELLATION INSTRUCTIONS - Group Administrator to complete this section to remove employees from group coverage.**

Please complete each section below in full to remove an employee from coverage. To assist you, Reason Codes are listed to the right.

<b>TE</b> = Terminated Employment	<b>CE</b> = COBRA Cancellation or Expiration	Please indicate the appropriate reason code below.	EFFECTIVE DATE - Enter the exact month, day and year the employee terminates employment or voluntarily terminates coverage. Enter the exact date of death if deceased.
<b>DR</b> = Cancellation of Coverage (still employed)	<b>RH</b> = Reduction in Hours		
<b>DE</b> = Employee is Deceased			

EMPLOYEE SOCIAL SECURITY #	NAME OF EMPLOYEE BEING CANCELED	REASON CODE	EFFECTIVE DATE
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			