blue california

Group cancellation form

Complete this form if the group would like to cancel group medical, dental, vision, and/or life insurance coverage. Please type or print. Use black ink. ***Note: Please complete all sections and submit to Small.Group@blueshieldca.com**

Group name **Group number**

Which product(s) would you like to cancel?

- ☐ Medical
- ☐ Dental
- ☐ Vision
- ☐ Life
- ☐ All of the above

Date of cancellation (MM/DD/YY):

Note: Small Groups are cancelled on the last day of each month. Example: Groups cancelling on 2/1/24 will be cancelled effective 1/31/24.

Name of new carrier (if applicable)

Reason for cancellation

Select reason

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of authorized group representative **Date**

Printed name of authorized group representative **Job title**