

For Highmark & Association Use Only		
Association Received Date	___/___/___	___/___/___
Highmark Received Date	___/___/___	___/___/___

AUTHORIZATION TO CANCEL HIGHMARK SMALL BUSINESS COVERAGE

Thank you for your enrollment in a Highmark Small Business health care program. It has come to our attention that you wish to terminate your Small Business coverage at this time. To do so, we ask that you complete and sign this Authorization to Cancel Highmark Small Business Coverage form and return it as soon as possible to the following address:

Highmark Blue Cross Blue Shield
 Small Group Marketing
 120 Fifth Avenue, Suite P2504
 Pittsburgh, PA 15222-3099

► **Please note that if you obtained your Highmark coverage through an association, you will need to send this form to both Highmark and the association. The association is required to send a copy of this form to Highmark for cancellation. This requirement is in addition to specific Highmark/Third Party Administrator cancellation procedures.**

By signing below, I hereby authorize that my Small Business coverage may be terminated (*check one*):

- Medical Coverage Only
- Vision Coverage Only
- Both Medical & Vision Coverage

Client Name: _____

Client Number: _____

Group Number(s): _____

Requested Cancellation Date: _____

(Please note that coverage will be cancelled on the **first of the month following the postmarked date of this form. Any premium payment made for coverage beyond the cancellation date will be refunded.** Retroactive employer cancellations are **not** permitted. Any premium payment due to Highmark for month(s) prior to termination will be collected.)

Reason for termination (*check all that apply*):

- Cost
- Obtained Other Coverage (Carrier's Name: _____)
- Other: _____
(please specify)

Would you like to be contacted by a Highmark Representative? Yes No

Employer's Name: _____ Title: _____

Employer's Signature: _____ Date: _____

White Copy: Highmark Pink Copy: Association Yellow Copy: Employer