BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

HMO Louisiana, Inc.
A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

SOUTHERN NATIONAL LIFE INSURANCE COMPANY, INC.
A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

COVERAGE CANCELLATION

GROUP NAME	GROUP NUMBER

Coverage with Blue Cross and Blue Shield of Louisiana will terminate on the following employees:

EMPLOYEE'S NAME	CONTRACT NUMBER
EMPLOYEE'S ADDRESS	

Please check which product(s) are to be cancelled and date the deletion is to be effective.

❑ Health ❑ Dental ❑ Group Term Life ❑ Other/Ancillary Product _____ Last Date of Employment _____

CONTRACT NUMBER	REQUESTED TERMINATION DATE	REASON	DATE OF DEATH

DEPENDENT'S NAME	RELATIONSHIP
DEPENDENT'S NAME	RELATIONSHIP
DEPENDENT'S NAME	RELATIONSHIP
DEPENDENT'S NAME	RELATIONSHIP

Check all that apply to be cancelled or "All Products"

❑ Spouse Only ❑ Children Only ❑ All Dependents ❑ Health ❑ Dental ❑ Group Term Life ❑ Vision
❑ Other/Ancillary Products _____ ❑ All Products/Entire Policy

X _____ _____
EMPLOYEE SIGNATURE DATE

By submitting a request to cancel any individual's coverage on this form, the Group/Employer/Company states:

- That neither the Member nor his/her dependent being cancelled has made payment towards the cost of premiums for any period beyond the date the group is requesting the coverage to be terminated. Excepted are employee contributions towards the cost of family coverage when termination of a dependent does not affect the total cost of the employee premium for a period after the date the cancellation is being requested.
- That no information was provided or representation made to the member or his/her dependent being cancelled that would create an expectation that the individual's coverage would continue beyond the date of the requested coverage termination, except for legally required disclosures regarding rights to COBRA or other mandated form of continuation coverage.

The group understands that both of these statements have to be met in order to cancel any individual's coverage pursuant to the Patient Protection and Affordable Care Act's (PPACA) prohibition on rescissions, and agrees to hold the health insurer harmless for any consequence related, directly or indirectly, to the falsity or inaccuracy of any of these statements. The group further understands that an individual may have a right to contest the cancellation of his/her coverage under the law, and that cancellations of coverage determined to have been made against the law under an internal and/or external review procedure, or order from an administrative agency or court, may require the reinstatement of the individual's coverage or the modification of the individual's cancellation date. In such event, the group will be responsible to pay the corresponding premiums for the individual's coverage, along with any other indemnifications, fines, penalties or other legal remedies, including attorney fees and costs, in which might have been incurred by or imposed upon the health insurer under that procedure.

X _____ _____
SIGNATURE OF AUTHORIZED REPRESENTATIVE OF THE GROUP DATE

Please fax this form to (225) 298-2988 or mail to: **Blue Cross and Blue Shield of Louisiana**
Attention: Membership and Billing Department
P. O. Box 98029
Baton Rouge, LA 70898-9029