



## COVERAGE CANCELLATION

GROUP NAME		GROUP NUMBER	
EMPLOYEE'S NAME		CONTRACT NUMBER	
EMPLOYEE'S ADDRESS		SOCIAL SECURITY NUMBER	
LAST DATE OF EMPLOYMENT	DATE OF DEATH	LAST DATE OF COVERAGE	REASON FOR CANCELLATION
<small>*Disability Termination is the Last Date of Employment</small>			
<b>PLEASE CHECK ALL THAT APPLY:</b>			
<input type="checkbox"/> <b>Cancel/Terminate Entire Contract (all BCBSLA, HMO LA, SNL and EQUITABLE**** products will be cancelled)</b>			
<input type="checkbox"/> <b>Cancel/Terminate EMPLOYEE PRODUCT(S) (select which BCBSLA, HMO LA, SNL and/or EQUITABLE**** products below to be cancelled)</b>			
<input type="checkbox"/> Medical	<input type="checkbox"/> **Group Term Life/AD&D	<input type="checkbox"/> ***Voluntary Group Term Life/AD&D	<input type="checkbox"/> Voluntary Short Term Disability
<input type="checkbox"/> Dental	<input type="checkbox"/> Dependent Life only	<input type="checkbox"/> Voluntary Spouse Life only	<input type="checkbox"/> Voluntary Long Term Disability
<input type="checkbox"/> Vision	<input type="checkbox"/> Short Term Disability only	<input type="checkbox"/> Voluntary Child Life only	<input type="checkbox"/> Voluntary High Limit AD&D
<input type="checkbox"/> <b>Cancel/Terminate DEPENDENT(S) (complete the next section)</b>			
<b>COMPLETE THE FOLLOWING SECTION FOR CANCELLATION OF DEPENDENT COVERAGE:</b>			
SPOUSE'S NAME	RELATIONSHIP	Products: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Voluntary Spouse Life	
DEPENDENT'S NAME	RELATIONSHIP	Products: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
DEPENDENT'S NAME	RELATIONSHIP	Products: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
DEPENDENT'S NAME	RELATIONSHIP	Products: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	

\*\*Terminating Group Term Life/AD&D will automatically terminate Dependent Life

\*\*\*Terminating Voluntary Group Term Life/AD&D will automatically terminate Voluntary Spouse Life and Voluntary Child Life

**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**

\*\*\*\*All group life and disability income insurance products referenced as an "Equitable" product shown on this enrollment form are issued exclusively by Equitable Financial Life Insurance Company of America (Equitable America), an Arizona stock corporation with its main administrative office in Jersey City, NJ. This is not a Blue Cross and Blue Shield of Louisiana product. Equitable America is solely responsible for its insurance and claims-paying obligations.





Blue Cross and Blue Shield of Louisiana  
HMO Louisiana  
Southern National Life

## **Nondiscrimination Notice**

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@bcbsla.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

### **1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.**

Section 1557 Coordinator  
P. O. Box 98012  
Baton Rouge, LA 70898-9012  
225-298-7238 or 1-800-711-5519 (TTY 711)  
Fax: 225-298-7240  
Email: Section1557Coordinator@bcbsla.com

### **2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to [www.bcbsla.com/checkmyplan](http://www.bcbsla.com/checkmyplan).**

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

# NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨打 1-800-711-5519 (TTY 711)。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك. إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານພຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫຼຸບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرید.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)