HIGHMARK DELAWARE

For Highmark Use Only
Highmark Received Date _____

AUTHORIZATION TO CANCEL HIGHMARK SMALL BUSINESS COVERAGE

Thank you for your enrollment in a Highmark Small Business 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 your Sales Representative.

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

- ❑ Medical Coverage
- ❑ Dental Coverage
- ❑ Vision Coverage
- ❑ FSA
- ❑ HSA

Client Name: _____

Client Number: _____

Group Number(s): _____

Agency Name: _____

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
  - ❑ No Longer Offering Group Coverage
  - ❑ Moving to another carrier *(Please list carrier name)*: _____
- ❑ Network
  - ❑ Moving to another carrier *(Please list carrier name)*: _____
- ❑ Other: ***(please specify)*** _____

Authorized Representative Name: _____

Authorized Representative Title: _____

By typing your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

Authorized Representative Signature: *(please hand sign if this is a paper request)* _____ Date: _____