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 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 SmallGroupCancel@highmark.com

▶ **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 all that apply):*

❑ Medical Coverage ❑ HRA

❑ Vision Coverage ❑ FSA

❑ Dental Coverage ❑ 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

❑ Obtained Other Coverage (Carrier's Name:) _____

❑ Other: _____
(please specify)

Employer's Name: _____ Title: _____

Employer's Signature: _____ Date: _____

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