

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:

- Via Fax: 1-888-567-5685
- Via Email: HHICGroupAppl@highmark.com
- Via U.S. Mail: Highmark  
P.O. Box 890172  
Camp Hill, Pennsylvania 17089-0172

► **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*):

- |                                           |                              |
|-------------------------------------------|------------------------------|
| <input type="checkbox"/> Medical Coverage | <input type="checkbox"/> HRA |
| <input type="checkbox"/> Vision Coverage  | <input type="checkbox"/> FSA |
| <input type="checkbox"/> Dental Coverage  |                              |

**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: \_\_\_\_\_