

EHA NOTICE OF RETIRING OR TERMINATING GROUP COVERAGE (AGE 50 AND OVER)

Independent Licensee of the Blue Cross and Blue Shield Association. GROUP COVE		OUP COVERAGE
Date:	(AGE	50 AND OVER)
Group Name:	Group Number:_	
Whenever an employee age 50 or over retires of Alliance group plan, please complete the inform so that we can confirm eligibility requirements for Senior Classic Medicare Supplement Plan. Please	ation requested below or the Direct Bill Plan o	and send it to us or the NSEA-R Blue
Blue Cross and Blue Shield of Nebraska 1233 Lincoln Mall, Suite 100 Lincoln, NE 68508-3912 Fax: (402) 477-2952		
Terminating Subscriber/Dependent Name	I.D. Number	Date of Coverage Termination
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