



AUTHORIZATION TO REMOVE DEPENDENT FROM APPLICATION

Applicant Name: _____

Applicant SSN: _____

I hereby authorize Blue Cross of Idaho to remove the following dependent(s)* from my Blue Cross of Idaho enrollment application.

Name	Date of Birth

**You cannot remove the original applicant from the application. You may only remove dependents.*

Please complete the following steps before returning this form to Blue Cross of Idaho.

1. If you remove a dependent prior to receiving a quote, please skip #2 and sign and date this form. If you received your Acceptance Form, please read and complete the next step, sign, and date this form.
2. Removing a dependent from your application may change the rate level (up or down) and therefore the cost of your coverage. If you remove a dependent after Blue Cross of Idaho has issued a quote, contact your local Blue Cross of Idaho district office at 800-365-2345 so that we may re-evaluate your rate level. Please write in your new rate level below. You must still complete, sign, and date your Acceptance Form.

New RL: _____ Initial: _____

If you have any questions, please contact your local Blue Cross of Idaho district office at 800-365-2345.

Applicant's Signature

Date