Empire BCBS High Option Disenrollment Request Form

HR-BEN-436

Section 1 - Information and Instructions

The purpose of this form is to terminate your enrollment in the Empire Blue Cross Blue Shield High Option medical and dental coverage.

Please send a signed copy of the form via fax to 212-852-8700, email to bscservice@mtabsc.org, mail to MTA Business Service Center, 333 W. 34th Street, New York, NY 10001 or drop off at NYCT Walk-in Center at 130 Livingston Street, 6th Floor, Brooklyn, NY, 8:30 a.m. to 5 p.m.

NOTE: THIS FORM MUST BE SUBMITTED NO LATER THAN AUGUST 11, 2014.

If you have any questions, please contact the Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section 2 - Member Information

Print Name	Last First M.I. Suffix	BSC ID
Member Identification Number ME		Phone
Street Address		
City	State	Zip Code

Section 3 - Authorization

1. I understand that by signing this disenrollment request I elect to terminate from the Empire BCBS High Option. I understand the following benefits will end:
   a. GHI Preferred Dental
   b. Dental and vision coverage up to age 21 for dependent children
   c. 365 days in hospital
   d. Increased reimbursement for out-of-network covered services
2. I understand the current payroll deduction for the High Option will end on the first paycheck of September.
3. I understand that I will automatically return to the Empire BCBS Basic medical coverage.
4. I understand that the effective date of this disenrollment will be September 1, 2014.

NOTE: Once you elect to terminate your membership, you will not be permitted to re-enroll in High Option until the second Annual Enrollment Period after termination, which will be in the fall of 2015.

This request must be signed by the member unless there is an appointed Durable Power of Attorney, a copy of which must be attached.

Member Signature	Date	SSN Last 4 Digits