BlueAdvantage
Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

AUTHORIZED REPRESENTATIVE CANCELLATION FORM

I, _____ hereby cancel the authorization previously granted to
(member name)

_____, whose address is
(name)

_____
street city state zip code

and telephone number is (____)_____, to communicate with

BlueAdvantage Administrators of Arkansas on my behalf regarding the

_____
(service, supply, prescription drug, equipment or treatment)

performed or to be performed on_____,200__ by _____.
(physician or health care provider)

This cancellation revokes the previous request to send all correspondence, notices and benefit determinations in connection with my health claim to the Authorized Representative. I understand and agree that it will take BlueAdvantage Administrators of Arkansas a reasonable period, approximately thirty (30) days, to notify all its personnel about the termination of this appointment of the Authorized Representative and it is possible that the Company may communicate information about me to the Authorized Representative during this notification period.

_____ _____
Member Signature Date Signed

_____ _____
Member Name (Printed) BlueAdvantage I.D.#