Small Group Your Blue Shop Removal Request

Group Name:_____

Current Renewal Month: _____

Group Number:_____

As an Authorized Representative of the above named Group, I request to be removed from the Your Blue Shop exchange effective on my next plan renewal date.

❑ I would like to utilize BCBSRI's Electronic Enrollment Tool, Digital Health Plan (DHP).

If you would like to use DHP, please complete the ***Electronic Enrollment Authorization Form*** *that is located on the employer portal. DHP enrollment may not be available immediately after termination of your Blue Shop exchange enrollment. If you have any questions, please contact your Sales Representative.*

Requested By: _____

Authorized Signature

Print Name: _____

Title: _____

Date: ____ / ____ / _____

500 Exchange Street • Providence, RI 02903-2699

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