



**St. Luke's Health Plan, Inc.**  
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# Cancellation of Authorized Representative - Group

To cancel a previous approval of an Authorized Representative, please fill out all the information below and return it to us. If you cancel your Authorized Representative, we will stop sharing any and all information with that person.

**Employer Name:** \_\_\_\_\_

**Group ID #:** \_\_\_\_\_

**Employer Contact Name:** \_\_\_\_\_

**Employer Title:** \_\_\_\_\_

**Employer Phone:** \_\_\_\_\_

**Employer Email:** \_\_\_\_\_

I hereby revoke any previous approval(s) of the person below to act as an Authorized Representative:

**Name of Previously Designated Representative:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

This cancellation will be effective as soon as possible after receipt of this form by St. Luke's Health Plan.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_