

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: _____