Employee Change Form

Return completed forms by:

- Mail: BCBSND
  Attn: Enrollment Department
  4510 13th Ave. S.
  Fargo, ND 58121

Group Information
Group Name (please print)

Employee Information	
Employee Name (please print)	Unique Member Identifier

Request for Updating Employee Information

Updating Employee Information		
☐ Name Change	Effective Date (MM/DD/YYYY)	
☐ Address Change	Effective Date (MM/DD/YYYY)	
Name Change		
First Name	Middle Name	Last Name
Address Change		
Address Line 1		
Address Line 2		
City	State	Zip

Request for Cancellation **(Reason field is required. Cancellation may be delayed without completing reason.)**

Employment Terminated ☐ Yes ☐ No Reason____

Cancellation	
☐ BCBSND health Group Number:___________________	Effective Date (MM/DD/YYYY)
☐ Dental coverage Group Number:___________________	Effective Date (MM/DD/YYYY)
☐ Vision coverage Group Number:___________________	Effective Date (MM/DD/YYYY)

Group Contact

Group Contact Information	
Name (please print)	Phone Number
Authorized Signature	Date

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