Employee Cancel

Return completed forms by:

- Mail: Blue Cross Blue Shield of North Dakota
  Attn: Enrollment Department
  4510 13th Ave. S.
  Fargo, ND 58121
- Email your BCBSND Representative

Client Information	
Client Name	Client Number

Employee Information		
Employee Name		
UMI/Agreement Number	Social Security Number	Last Day of Employment

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

Cancellation	
BCBSND Health Group Number:_____	Cancel Date (MM/DD/YYYY)
Reason for BCBSND Health Cancellation	
Name of Policyholder and/or Dependent(s)	
Dental Coverage Group Number:_____	Cancel Date (MM/DD/YYYY)
Reason for Dental Coverage Cancellation	
Name of Policyholder and/or Dependent(s)	
Vision Coverage Group Number:_____	Cancel Date (MM/DD/YYYY)
Reason for Vision Coverage Cancellation	
Name of Policyholder and/or Dependent(s)	

Client Contact Information	
Name	Phone Number
Authorized Signature	Date (MM/DD/YYYY)