



Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross Blue Shield Association

REQUEST FOR TERMINATION

- 1. Please print in black ink. Incomplete and/or illegible information may result in delayed processing.
- 2. **This form must be signed and dated by an Authorized Group Contact or it will be returned.**
- 3. Use the fax number or mailing address at the top of this form and return it to the attention of the Membership Administrator indicated on your bill.

SECTION 1 – GROUP INFORMATION

Group Number	Group Name

SECTION 2 – EMPLOYEE AND DEPENDENT TERMINATION INFORMATION

Please complete each section below to remove an employee or his/her dependent(s) from Medical and/or Dental coverage.

Employee or Dependent Name	Date of Birth	Reason for Termination	Last Date of Coverage*	Coverage to Terminate
1.				☐ Medical ☐ Dental
2.				☐ Medical ☐ Dental
3.				☐ Medical ☐ Dental
4.				☐ Medical ☐ Dental
5.				☐ Medical ☐ Dental
6.				☐ Medical ☐ Dental

SECTION 3 – AUTHORIZED SIGNATURE

This confirms that any employee and/or dependent for whom retroactive termination for administrative delay is requested had no expectation of coverage and paid no premium after the requested termination date.

Signature of Authorized Group Contact: _____

Signature Date: _____

Printed Name of Authorized Group Contact: _____

*Last date of coverage is typically the last day of the month (not the last day of work) except, e.g., if your contract offers mid-month terminations, or on the date of an employee/dependent’s death.

Blue Cross Blue Shield of North Dakota: 4510 13th Avenue South, Fargo, ND 58121

