Coverage Change Request Form

Use this form only if you are:

1. Currently enrolled in one of the employers health plans; and
2. Keeping the SAME individuals covered (no change in dependent coverage). If you are adding or removing dependents, a group application is required; and
3. Electing to change to the selected health plan below.

Return completed forms by:

- Mail: Blue Cross Blue Shield of North Dakota
  Attn: Enrollment Department
  4510 13th Avenue S.
  Fargo, ND 58121

Coverage Change – Option 1	
☐ I Elect	Health Group Number
Network Name (if applicable)	

OR

Coverage Change – Option 2	
☐ I Elect	Health Group Number
Network Name (if applicable)	

OR

Coverage Change – Option 3	
☐ I Elect	Health Group Number
Network Name (if applicable)	

Employer Information	
Employer Name	Phone Number

Employee Information		
First Name	MI	Last Name
Unique Member Identifier (UMI)	Requested Effective Date	
Work Phone Number	Home Phone Number	
Signature	Date	