Blue Cross and Blue Shield of New Mexico

Mail completed form to:
Membership Dept., BCBSNM
P.O. Box 27630
Albuquerque, NM
87125-7630

Fax To: (505) 837-8950

Group Employee Termination Form

Account Name_____ Group Number_____

Please use this form for contract terminations. Additional forms can be downloaded from www.bcbsnm.com. (You must submit a Group Enrollment/Change Application form for all changes including adding or dropping dependents, name or address changes, and new enrollees.)

EMPLOYEE NAME	SOCIAL SECURITY #	REMARKS	EFFECTIVE DATE	ADJUSTMENT

Signature _____ Date _____

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and Independent Licensee of the Blue Cross and Blue Shield Association.