



KEY WORD	CERTIFICATE NO.	NAME OF SUBSCRIBER (LAST NAME, FIRST)	GROUP NUMBER AND SECTION		EFFECTIVE DATE	HEALTH INS. TYPE
			EXISTING	NEW (FOR TRANSFER)		

**KEY WORD EXPLANATION**

- ADD** NEW HIRE—Completed and signed Group Enrollment Form required. Ensure that the date placed in the “Date of Hire” block on the Enrollment Form is the date the employee was hired FULL TIME.
- LE** LEFT EMPLOYMENT—For employees not electing Continuation Coverage.
- CHANGE** ANY CHANGE IN COVERAGE—Complete a Group Enrollment Form.
- DECEASED** Put “Date of Death” in the effective date column. Complete a Group Enrollment Form for surviving dependents on Continuation Coverage (if applicable).
- CANCEL** If subscriber requests Voluntary cancellation, complete a Group Enrollment Form. Indicate if termination of Continuation Coverage.
- RE-ENROLL** Continuation of employment or COBRA/VIPER election. Indicate if Continuation Coverage.
- TRANSFER** From “existing” group/section to “new” group/section.
- OTHER** Attach explanation.

**REMINDER: THIS GROUP MEMBERSHIP UPDATE SHOULD ACCOMPANY GROUP ENROLLMENT FORMS AND MUST BE SUBMITTED PRIOR TO THE EFFECTIVE MONTH FOR ALL CHANGES.**

**FOR OFFICE USE ONLY**

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COMPLETED BY

\_\_\_\_\_

DATE

THIS NOTICE PREPARED BY

\_\_\_\_\_

SIGNATURE

\_\_\_\_\_

DATE

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PHONE NO.