

An Independent Licensee of the Blue Cross and Blue Shield Association. P.O. Box 186 Montpelier, VT 05601-0186

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KEY WORD	CERTIFICATE NO.	NAME OF SUBSCRIBER (LAST NAME, FIRST)	GROUP NUMBE EXISTING	R AND SECTION NEW (FOR TRANSFER)	EFFECTIVE DATE	HEALTH INS. TYPE	
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	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	R. THIS GROUP MEM	BERSHIP UPDATE SHOULD ACC	OMPANY GROUI	P ENROLL MENT F	ORMS		
HEMINDE	AND MUST BE SUE	BMITTED PRIOR TO THE EFFECT	IVE MONTH FOR	ALL CHANGES.	OTIMO		
FOR OFFICE USE ONLY			THIS NOTICE PREPARED BY				
COMPLETED BY		-	SIGNATURE				
DATE		DATE		PHONE NO.			