

SECTION I

Please use separate form for Medicare enrollees.		Page _____ of _____ Page _____	Plan (please check one) <input type="checkbox"/> EmblemHealth <input type="checkbox"/> GHI <input type="checkbox"/> GHI HMO <input type="checkbox"/> HIP	
Employer Group Number	Line of Business Rider	Prepared by	Title	Date of Preparation

SECTION II

Employer Group Name and Address	Return completed copies to:
	EMBLEMHEALTH ENROLLMENT DEPARTMENT P.O. Box 2806 New York, NY 10116-2806

SECTION III

TO BE COMPLETED BY EMPLOYER OR AGENT																
1. I.D. Number/S.S. Number										2. Name of subscriber			*3. Type of change or termination	4. Effective date of change or termination	Remarks	Email
										Last	First	MI				
1.																
2.																
3.																
4.																
5.																
6.																
7.																
8.																
9.																
10.																

SECTION IV

*Use the following codes to indicate type of transaction in Column 3		
Change – 1 = Add Newborn 2 = Reinstatement 3 = COBRA 4 = Address Change 5 = Remove Dependent 6 = Name Change 7 = Group Change	Termination – 57 = Resignation of Subscriber From Group 71 = Deceased 72 = Member Non-Payment of Premium 80 = Transfer to Another Plan or Carrier 84 = Out of Service Area	88 = Dissatisfied With Medical Service - Member 94 = Dissatisfied With Medical Service - Group 97 = Dissatisfied With EH Administrative Services - Member 98 = Dissatisfied With EH Administrative Services - Group