Employee Health Insurance Management

Employee Enrollment/Change of Status Notification Form

☐ New Enrollee	☐ Termination	☐ Status Change	Enrollment Type	☐ Medical	☐ Pharmacy	☐ Dental

Group Name:	Group Number:	Coverage Effective Date:

Social Security Number:	Cardholder Name (First, Middle Initial, Last):	Gender: ☐ M ☐ F	Date of Birth:

Address: Check if address update ☐	City:	State:	Zip Code:

Phone Number:	Current Health Insurance Program:	Hire Date:

Company Division (if applicable):	Location Code (if applicable):	Department Code (if applicable):

DEPENDENTS TO BE INSURED/TERMINATED

Add/Term	Relationship	Social Security #	Name	Date of Birth	Medicare Eligible	Gender
	Spouse				☐ Y ☐ N	☐ M ☐ F
	Child				☐ Y ☐ N	☐ M ☐ F
	Child				☐ Y ☐ N	☐ M ☐ F
	Child				☐ Y ☐ N	☐ M ☐ F

TERMINATION INFORMATION

Action	Contract Number	Social Security #	Cardholder Name	Term Date	COBRA Offered
Terminate					☐ Y ☐ N

☐ Terminate ENTIRE CONTRACT ☐ Terminate SPOUSE only ☐ Terminate DEPENDENTS only (list dependents to terminate above)

COBRA INFORMATION

☐ COBRA has been elected for CARDHOLDER only.
☐ COBRA has been elected for CARDHOLDER & SPOUSE.
☐ COBRA has been elected for CARDHOLDER & FAMILY.
☐ COBRA has been elected for SPOUSE only.
☐ COBRA has been elected for DEPENDENTS only.
☐ Active COBRA Policy is being terminated.

Social Security Number	Name	COBRA Effective Date / COBRA Termination Date

I acknowledge that EHIM requires me to disclose specific identifying information when completing this application. I and my covered dependents agree to permit EHIM to release protected health information (PHI) for the purposes of administering this Plan as directed by the Plan Administrator and for other purposes necessary for EHIM to fulfill its contractual and statutory obligations.

Authorized Signature _____ Date _____

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