



MEMBERSHIP CHANGE REPORT

Employee Additions, Changes and/or Removals

Customer ID # _____

Group Name _____

Group Address _____

City _____ State _____ Zip _____

Phone Number _____ Email _____

Please check all that apply & fill in corresponding group #	
HMO/POS _____	Group # _____
PC / BC _____	Group # _____
UCCI _____	Group # _____
Other _____	Group # _____

Employee Name	Action Code*	Social Security or ID Number	Effective Date	Removal Code**	Remarks/Explanation

Date

Authorized Signature

Title

*Action Codes
A = Add Employee C = Change coverage or dependents(s) R = Remove Employee - <i>please enter the applicable Removal Code</i>

** Removal Codes
1 = Remove; employee quit 2 = Remove; employee laid off 3 = Remove; covered by spouse 4 = Remove; change to Medicare plan 5 = Deceased

Do not send this form with your premium payment, as payments go directly to the bank lockbox.

Questions? Call us at 215-674-9400 or 800-734-9400