Notice of Membership Adjustment

(For new enrollments, changes, or terminations)

PAGE _____ OF _____

_____
DATE

CIGNA HealthCare of New Hampshire
PO Box 2010
Concord, NH 03302-2010

_____
GROUP NAME

_____
GROUP NUMBER AND SECTION

INSTRUCTIONS
Please complete columns 1-5.
Use the appropriate codes, as designated below:

COLUMN	HEADING	DESCRIPTION
1	KEY WORD	
	CANCEL	If Subscriber requests Voluntary cancellation, complete Notice of Membership Adjustment Form.
	CHANGE	CHANGE IN COVERAGE - Complete a Group Application and Notice of Membership Adjustment Form.
	COBRA	Employee has left employment and has indicated continuation of benefits through COBRA extension.
	DECEASED	Please use the day of Death as the effective date. Complete a Group Application and Notice of Membership Adjustment Form.
	LE	LEFT EMPLOYMENT
	NE	NEW EMPLOYEE - Signed and completed Group Application and Notice of Membership Adjustment Form required. The date placed in the "Date of Hire" block on the Application Form must be the date the employee was hired FULL TIME.
	AM	ADD FAMILY MEMBER - Indicate reason (marriage, birth, etc.) and effective date (date of the event). (Membership Application signed and completed).
	OTHER	Attach explanation.
2	CIGNA HEALTHCARE MEMBER ID NO. OR SOCIAL SECURITY NO.	Subscriber Billing Number
3	NAME OF SUBSCRIBER	Subscriber's name (Last name, first name, middle initial)
4	EFFECTIVE DATE	Effective date of change NOTE: Termination date on change form should be date employee will be removed from CIGNA HealthCare policy.
5	CONTRACT TYPE	S=Single D=2 Person F=Family

1 KEY WORD	2 CIGNA HEALTHCARE MEMBER ID NO.	3 NAME OF SUBSCRIBER (LAST NAME FIRST)	4 EFFECTIVE DATE	5 CONTRACT TYPE

THIS NOTICE PREPARED BY

_____
COMPANY REPRESENTATIVE SIGNATURE

_____ _____
DATE PHONE NO.

_____
EXTENSION

ORIGINAL COPY MUST ACCOMPANY ALL APPLICATION FORMS, AND SHOULD BE SUBMITTED PRIOR TO THE EFFECTIVE MONTH. TERMINATIONS, ADDITIONS (i.e.: Births, Marriages, etc.) MUST BE SUBMITTED **IMMEDIATELY.**

NOTE: CHANGES MUST BE MADE WITHIN 31 DAYS OF THE EVENT.

GROUP # CIGNA HEALTHCARE USE ONLY

576634 Rev. 10/2004

White - Original **Canary -** Mail With Payment **Pink -** Keep For Your Records