Notice of Membership Change Form

(Includes Membership Additions)

Anthem®

Group Name
Firm/Firm Division #
Invoice Number
Due Date

Keyword (See Reverse Side)	Subscriber Cert. #	Name of Subscriber (Last Name First)	Effective Date	Health Ins. Type	Life Ins. Class	Plus	Minus

This Notice Prepared by Benefit Administraton

Signature

Date Phone

For Office Use Only Comments

Membership Specialist

Date Completed

$ 0.00 $ 0.00

Clear Plus & Minus

Refer to These Instructions

INSTRUCTIONS

KEY WORD

ADD	An Enrollment and Change Form, completed and signed by the employee, is required. Please ensure that the date placed in the Date of Hire block on the Enrollment and Change form is the date the employee was hired full time. Include life insurance class if applicable. Include the Certificate Number (Social Security Number) and indicate the effective date of health insurance benefits on this form.
TRANSFER	If an employee is presently covered under Anthem Blue Cross and Blue Shield and is transferring to your company or to a different group within your company, the employee may be required to fulfill your company's probationary period. **NOTE: An Enrollment and Change Form must be completed if:** • **The employee is a new hire to your company.** • **The employee requests a change in type of membership or benefit level.**
LE	LEFT EMPLOYMENT – If the group termination policy is Date of Term, the effective date you indicate should be the last day of employment. If the group termination policy is End of the Month, the effective date you indicate should be the end of the month in which the termination of employment occurred.
CHANGE	An Enrollment and Change Form, completed and signed by the employee, is required for any change in coverage.
DECEASED	The effective date you indicate should be the last day of the month during which the death occurred. A completed and signed Enrollment and Change Form is required if the deceased was a dependent. If the date of death was more than six months ago, please include a copy of the Death Certificate.
CANCEL	If the subscriber is employed and does not wish to continue coverage. The cancellation date will be determined by the group's termination policy. If the group termination policy is Date of Term, the effective date you indicate should be the last day of coverage. If the group termination policy is End of the Month, the effective date you indicate should be the end of the month in which the termination of coverage occurred. **NOTE: Employee may only re-enroll on your group's anniversary month or due to a qualifying event.**
STATE/FEDERAL CONTINUATION	For continuity of coverage under State/Federal Laws, the effective date you indicate should be the day after the employer elects to terminate coverage. An Enrollment and Change Form must be completed if the beneficiary is a dependent or the former employee is requesting a change to their coverage.
STATE/FEDERAL TERMINATION	If the employee is terminating coverage that has been active under State/Federal Continuation Laws, the effective date you indicate should be the last day of the month during which the continuity of coverage ends.
OTHER	Please attach explanation.

Please submit by mail **OR** by fax, but not by both methods.

Mail to: Anthem Blue Cross and Blue Shield, 3000 Goffs Falls Road, Manchester, NH 03111-0001

Fax to: 603-645-5830