



GUIDELINES FOR MAKING CHANGES TO YOUR GROUP INSURANCE BILL

**PLEASE DO NOT SEND CORRESPONDENCE OR TERMINATIONS ALONG WITH YOUR PAYMENT
FAX THIS FORM TO (248) 733-6370**

TO ADD EMPLOYEES AND DEPENDENTS

For information on how to add new employees and their dependents or how to enroll newly eligible dependents, please refer to your Employer's Kit.

TO DELETE EMPLOYEES AND DEPENDENTS FROM YOUR PLAN

When eligibility ends for such reasons as reduction in hours, termination of employment, divorce, a child's 25th birthday, etc.,

PLEASE NOTIFY US by completing the information below, including the reason for and the date of termination and FAX this form to 1-248-733-6370

PLEASE NOTE THAT coverage for terminated employees and dependents continues until the end of the premium month in which they cease to be eligible. Premiums must be paid for the entire premium month.

All terminations are effective on the last day of the month **FOR GROUPS BILLED ON THE 1ST** and on the **14TH FOR GROUPS BILLED ON THE 15TH**. Terminations must be received in our office within 30 days from the effective date of termination to ensure proper credit to your account. If an employee or dependent has terminated as of the premium due date, adjustments will appear on your next billing statement.

NEXT MONTH'S BILL

To ensure that your terminations and premium adjustments appear on your next bill, we must receive notifications by the bill due date. Notifications received after the due date may take an additional billing cycle to appear on your next billing statement.

CONTINUATION OF COVERAGE

When a member or dependent terminates from the group plan, they may be entitled to continue or convert their group coverage. These rights are described in the Group Service Agreement. If your firm normally employs 20 or more employees, terminating employees and dependents may have the right to continue coverage under COBRA laws. COBRA information and sample forms are included in your Employer's Kit.

WHEN YOU COMPLETE THE INFORMATION BELOW please be sure to notify terminating employees and dependents of their Federal COBRA, Florida Continuation or conversion rights.

IF YOU PROVIDE PRESCRIPTION DRUG BENEFITS, please remember to collect and destroy ID card(s) from terminating employees and dependents.

THANK YOU FOR CHOOSING NEIGHBORHOOD HEALTH PARTNERSHIP TO SERVE YOUR INSURANCE NEEDS

Group Number

Group Name

TERMINATION REASON CODES	
TC Termination or Employment	DV Divorce or Legal Separation
RH Reduction in Hours	DO Loss of Dependent status
LO Layoff	ME Medicare Entitlement of Employee
WW Death of Employee	NQ Non Qualifying Event (Term by Choice)

I. DELETE EMPLOYEES:

Employee Name	Member Number	Term Code	Term Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I. DELETE DEPENDENTS:

Employee Name	Member Number	Dependent Name	Term Code	Term Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

III. EMPLOYER CHANGE OF BUSINESS ADDRESS/ PHONE NUMBER

EFFECTIVE DATE OF CHANGE: _____

STREET NUMBER CITY STATE ZIP CODE PHONE NUMBER

AUTHORIZED SIGNATURE: _____
(REQUIRED FOR ANY CHANGES NOTED ABOVE)

DATE: _____