EmblemHealth®

MEMBER CHANGE FORM FOR GROUP ACCOUNTS

for reporting changes and terminations only

SECTION I

Please use separate form for Medicare enrollees.		Page _____ of Page _____	Plan (please check one) ☐ EmblemHealth ☐ GHI ☐ GHI HMO ☐ HIP	
Employer Group Number	Line of Business Rider	Prepared by	Title	Date of Preparation

SECTION II

Employer Group Name and Address	**Return completed copies to:**
	EMBLEMHEALTH ENROLLMENT DEPARTMENT P.O. Box 2806 New York, NY 10116-2806

SECTION III

TO BE COMPLETED BY EMPLOYER OR AGENT															
	1. I.D. Number/S.S. Number									**2. Name of subscriber** **Last First MI**	***3. Type of change or termination**	**4. Effective date of change or termination**	**Remarks**	**Email**
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														

SECTION IV

***Use the following codes to indicate type of transaction in Column 3**	
Change – 1 = Add Newborn 2 = Reinstatement 3 = COBRA 4 = Address Change 5 = Remove Dependent 6 = Name Change 7= Group Change	**Termination** – 57 = Resignation of Subscriber From Group 71 = Deceased 72 = Member Non-Payment of Premium 80 = Transfer to Another Plan or Carrier 84 = Out of Service Area 88 = Dissatisfied With Medical Service - Member 94 = Dissatisfied With Medical Service - Group 97 = Dissatisfied With EH Administrative Services - Member 98 = Dissatisfied With EH Administrative Services - Group

16-0685 4/14