

Add/Change/Termination Form GROUP ADMINISTRATION



A. GENERAL INFORMATION

Group ID Number _____ Group Name _____ Date ____ - ____ - ____
 Member ID # _____ Member Name _____

B. TRANSACTION

	EFFECTIVE DATE	REQUIRED INFORMATION
<input type="checkbox"/> Addition* Complete WHO, REASON and SECTION C * Provide documentation as required	____ - ____ - ____	WHO <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> NY Young Adult <hr/> REASON <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Civil Union <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____
<input type="checkbox"/> Information Change/Correction <input type="checkbox"/> Name <input type="checkbox"/> Date of Birth <input type="checkbox"/> SSN <input type="checkbox"/> Address <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Gender	____ - ____ - ____	Last Name _____ First Name _____ M.I. _____ Date of Birth ____ - ____ - ____ SSN _____ Address _____ City _____ State _____ Zip _____ Email _____ Phone _____ Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
<input type="checkbox"/> Termination	____ - ____ - ____	WHO <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> NY Young Adult Member ID # _____ Member Name _____ <hr/> REASON <input type="checkbox"/> Left Employer <input type="checkbox"/> Discontinuation of COBRA <input type="checkbox"/> Switched Plans <input type="checkbox"/> Discontinuation of NY Young Adult <input type="checkbox"/> Other _____
<input type="checkbox"/> Change Plan Complete entire section	____ - ____ - ____	New Plan _____ Reason _____
<input type="checkbox"/> COBRA or State Continuation	____ - ____ - ____	WHO <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner* <input type="checkbox"/> Dependents(s)* <hr/> REASON <input type="checkbox"/> Left Employer <input type="checkbox"/> Hours Reduction <input type="checkbox"/> Other _____ Date of Event ____ - ____ - ____ *A New Member Enrollment Form is required for Loss of Dependent Status, Divorces/Separation or Death of Subscriber



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C. DEPENDENT INFORMATION

	SPOUSE/DOMESTIC PARTNER/CIVIL UNION	NEW DEPENDENT	NEW DEPENDENT
Social Security Number	_____	_____	_____
Last Name	_____	_____	_____
First Name, Middle Initial	_____	_____	_____
Date of Birth (mm/dd/yy)	____ - ____ - ____	____ - ____ - ____	____ - ____ - ____
Gender and Disability Status	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Disabled	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Disabled	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Disabled
Check "Yes" or "No"	Actively Employed <input type="checkbox"/> Y <input type="checkbox"/> N	N/A	N/A

D. COORDINATION OF BENEFITS

		SPOUSE	DEPENDENT	DEPENDENT
Medicare	Check appropriate box and list effective date	<input type="checkbox"/> Part A ____ - ____ - ____ <input type="checkbox"/> Part B ____ - ____ - ____ <input type="checkbox"/> Part D ____ - ____ - ____	<input type="checkbox"/> Part A ____ - ____ - ____ <input type="checkbox"/> Part B ____ - ____ - ____ <input type="checkbox"/> Part D ____ - ____ - ____	<input type="checkbox"/> Part A ____ - ____ - ____ <input type="checkbox"/> Part B ____ - ____ - ____ <input type="checkbox"/> Part D ____ - ____ - ____
Medical	<input type="checkbox"/> Same for all			
	Policy Number	_____	_____	_____
	Carrier	_____	_____	_____
	Policy Holder	_____	_____	_____
	Effective Date	____ - ____ - ____	____ - ____ - ____	____ - ____ - ____

All transactions are effective on the first day of the next month

The completed form must be signed and any required documentation sent to Health Republic Insurance of New York via one of the following methods:

Mail to:

Health Republic Insurance of New York
Attn: Pre-Enrollment
30 Broad St., 7th Floor
New York, NY 10004

Brokers – please email:

brokers@newyork.healthrepublic.us

Members or Group Administrators – please fax:

1-855-201-7829

If you have any questions please call our member services team at **888-990-5702**.

Group Administration Signature _____ Date ____ - ____ - ____

Member Signature _____ Date ____ - ____ - ____