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) ☐ GHI ☐ HIP ☐ HIPIC	
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. ID number/SS 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

16-0685PD 10/18