BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
P.O. Box 186
Montpelier, VT 05601-0186

GROUP MEMBERSHIP UPDATE

KEY WORD	CERTIFICATE NO.	NAME OF SUBSCRIBER (LAST NAME, FIRST)	GROUP NUMBER AND SECTION		EFFECTIVE DATE	HEALTH INS. TYPE
			EXISTING	NEW (FOR TRANSFER)		

KEY WORD EXPLANATION

ADD	NEW HIRE—Completed and signed Group Enrollment Form required. Ensure that the date placed in the "Date of Hire" block on the Enrollment Form is the date the employee was hired FULL TIME.
LE	LEFT EMPLOYMENT—For employees not electing Continuation Coverage.
CHANGE	ANY CHANGE IN COVERAGE—Complete a Group Enrollment Form.
DECEASED	Put "Date of Death" in the effective date column. Complete a Group Enrollment Form for surviving dependents on Continuation Coverage (if applicable).
CANCEL	If subscriber requests Voluntary cancellation, complete a Group Enrollment Form. Indicate if termination of Continuation Coverage.
RE-ENROLL	Continuation of employment or COBRA/VIPER election. Indicate if Continuation Coverage.
TRANSFER	From "existing" group/section to "new" group/section.
OTHER	Attach explanation.

REMINDER: THIS GROUP MEMBERSHIP UPDATE SHOULD ACCOMPANY GROUP ENROLLMENT FORMS AND MUST BE SUBMITTED PRIOR TO THE EFFECTIVE MONTH FOR ALL CHANGES.

FOR OFFICE USE ONLY

COMPLETED BY

DATE

THIS NOTICE PREPARED BY

SIGNATURE

DATE

PHONE NO.