EMPLOYEE ENROLLMENT/CHANGE/TERMINATION TRANSMITTAL FORM

SEND TO:
AMHIC / SBPA
1753 Pinnacle Drive 8th floor VA2005
McLean, Va 22102
Attn: Diane Sedor
EMAIL: AMHIC@Wellsfargois.com
FAX: (703) 760-5687
VOICE: (703) 760-6938

*Association:*______________________________________*Subgroup #:*_________

*Authorized Signature:*_____________________________*Date:*_________

Phone Number ______________________________

	EMPLOYEE NAME	CHANGE CODE (select code from list below)	COVERAGE EFFECTIVE DATE	DATE OF HIRE (please complete for new hires)	TERMINATION OF EMPLOYMENT DATE (if applicable)	Health (*PPO, *Network Only, *CareFirst or *Kaiser)	MetLife Dental	UHC Vision	EAP / **FSA / **Life / **Legal Resources	Comments orAddress Change - Please list complete new address: you may attach a second sheet if needed (two line maximum)
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Change Code:

1. *New Hire - New hires should complete AMHIC enrollment application, and attach a copy of the HIPAA certificate from your previous employer
2. Address Change
3. *Name Change (Need proof of change)
4. *Coverage Change
5. Termination of employment with all AMHIC coverages being terminated (coverage termination effective date is the end of the month.)
NCAS staff will contact employee/dependents regarding COBRA.
6. Change in status from active to retiree (if the employee/dependent is age 65 or over please attach a copy of their Medicare Parts A&B card.)
Please note: A copy of the employer's retiree policy must be on file with AMHIC in order to change to retiree status.
Please note: Kaiser retirees must fill out a Kaiser Medicare Plus application.
7. Termination due to dependent status change (coverage termination effective date is the end of the month. NCAS staff will contact dependent regarding COBRA.)
8. Termination due to death.
9. ID Card Replacement
10. Other
***Attach New Enrollment Form**
****Attach A separate application for each plan**

11/17/2009 last updated