

ENROLLMENT CHANGE SUMMARY

This form must accompany any New Enrollment Applications, Deletions, Changes (Family Medical Leave, Workers Comp), or COBRA Notifications

1. NAME OF EMPLOYER _____
2. REPORTING MONTH _____
3. SUMMARY OF TRANSACTIONS _____
 - A. Number of New Enrollment Forms Submitted _____
 - B. Number of Coverage Change Forms Submitted _____
 - C. Total Number of Forms Submitted _____
4. PLEASE COMPLETE THE AREA BELOW FOR ALL EMPLOYEES REPRESENTED IN THE "SUMMARY OF TRANSACTIONS" - #3 ABOVE.
5. CHANGE CATEGORIES MUST INCLUDE Family Medical Leave, Leaves of Absence, and Workers Comp.

Signature of Certifying Officer

Date

ADDITIONS AND CHANGES

Employee Name	Social Security Number/ ID Number	Effective Date	Type of Change

(Complete 2nd Page for any Terminations/COBRA/FMLA/Workers Comp.)

TERMINATIONS

Employee Name	Social Security Number/ ID Number	Reason	Termination Date

FAMILY MEDICAL LEAVE ACT

Employee Name	Social Security/ ID Number	FLMA Termination Date	Employment/ Coverage Reinstatement Date	Last Day Worked

WORKERS COMP

Employee Name	Social Security/ ID Number	Work Related Injury	Employment/ Coverage Reinstatement Date	Last Day Worked

COBRA NOTIFICATIONS

Employee Name	Social Security Number/ ID Number	Termination Date	Reinstate Date