SCHOOLCARE
370 Harvey Rd, Ste 4
Manchester, NH 03103
Attn: Linda Jo Demers
Phone: 800-562-5254 Fax: 603-369-4200

MEMBERSHIP ADJUSTMENT FORM

(For new enrollments, changes or terminations)

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_____
Date

_____
Group Name

_____
Group Number

Instructions

Please complete columns 1 – 5.
Use the appropriate code, as designated below:

COLUMN	HEADING	DESCRIPTION
1	KEY WORD CANCEL	If subscriber requests Voluntary Cancellation, complete Enrollment Change Form.
	CHANGE	Change in Coverage - Complete a Group Application and Enrollment Change Form.
	COBRA	Employee has left employment and has indicated continuation of benefits through COBRA extension.
	DECEASED	Please use the date of Death as the effective date.
	LE	Left Employment
	NE	New Employee - signed and completed Application and Enrollment Change Form required. The date placed in the "Date of Hire" block on the Application Form must be the date the employee was hired FULL TIME.
	AM	Add Family Member - Indicate reason (marriage, birth, etc.) and effective date (date of the event). (Application signed and completed)
	OTHER	Attach explanation.
2	Subscriber SSN	Subscriber Social Security Number
3	Name of Subscriber	Subscriber's name (Last name, first name, middle initial)
4	Effective Date	Effective Date of Change. NOTE: Termination date on change form should be date employee will be removed from Policy.
5	Contract Type	S = Single, D = 2 person F = Family

1 KEY WORD	2 SUBSCRIBER SSN	3 NAME OF SUBSCRIBER (LAST NAME FIRST)	4 EFFECTIVE DATE	5 CONTRACT TYPE

This Notice Prepared By

_____
Company Representative Signature

_____ _____
Date Phone Number

_____
Extension

ORIGINAL COPY MUST ACCOMPANY FORMS, AND SHOULD BE SUBMITTED PRIOR TO THE EFFECTIVE MONTH. TERMINATIONS, ADDITIONS (i.e.: Births, Marriages, etc.) MUST BE SUBMITTED **IMMEDIATELY.**

NOTE: CHANGES MUST BE MADE WITHIN 30 DAYS OF THE EVENT.