# ENROLLMENT CHANGE SUMMARY

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

(1)	Name o	of Employer		
(2)	Reporti	ng Month		
(3)	Summary of Transactions			
	(a)	Number of New Enrollment I	Forms Submitted	
	(b) Number of Coverage Change Forms Submitted			
	(c)	Total Number of Forms Subn	nitted	
(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 Offi	cer	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 Number/ID Number	FLMA Termination Date	Employment/ Coverage Reinstatement Date	Last Day Worked

## WORKERS COMP.

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

## **COBRA NOTIFICATIONS**

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