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 Number/ID Number	FLMA Termination Date	Employment/ Coverage Reinstatement Date	Last Day Worked

WORKERS COMP.

Employee Name	Social Security Number/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