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

TERMINATIONS

| Employee Name | Social Security Number/ID Number | Reason | Termination Date |
|---------------|-------------------------------------|--------|------------------|
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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 |
|---------------|-------------------------------------|------------------|----------------|
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