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Notice of Membership Change Form

Group Name: _____

Terminated: Voluntarily Involuntarily

KEY (SEE BELOW)	SOCIAL SECURITY NUMBER	SUBSCRIBER NAME (LAST NAME, FIRST)	EFFECTIVE DATE	TYPE	ACTION/COMMENT	GROUP/DIVISION NUMBER	COBRA ELIGIBLE (Y/N)

FSA ELIGIBILITY (IF APPLICABLE)	
ACTUAL LAST DATE WORKED	FSA CONTRIBUTION TO DATE

Notice Prepared by:

 Authorized Benefit Administrator's Signature

 Date

 Telephone #

KEY		TYPE
1 - Termination: Employment	8 - Dependent no longer eligible	1 - Single
2 - Death	9 - Moved out of area	2 - Two Person
3 - Divorce	10 - Plan change	2S - EE + Spouse
4 - Layoff without Benefits	11 - Voluntary withdrawal	2C - EE + Child
5 - Leave without Benefits	12 - Move to other HP Plan	3 - Family
6 - Retirement	13 - Not eligible	
7 - COBRA Termination		