Member Terminations/Changes

This document is for Terminated Members and Changes to Enrollment Only

Return To: Health Plan Administrators, LLC
54 Westchester Drive, Suite 20
Austintown, Ohio 44515

Fax To: (330) 953-2310

From: Group Name _____
Address:_____
_____
Phone:_____
Date:_____

Terminations Only			Member Changes			
Employee Name	ID Number	Term Date	Member Name	Eff. Change Date	Add/Terminate	Address Change

I hereby certify that the above information is complete and correct. By signing this form, if not the Employer, I represent that I have the authority to sign.

Signature of officer of employer, or employer's authorized representative	**Date**