HIP
HEALTH PLAN OF NEW YORK

Transmittal Sheet

For reporting changes and terminations only

Please use separate form for Medicare enrollees.	Page of Pages	Transmittal No. (HIP use only)

Employer Group Number	Line of Business Rider	Prepared by	Title	Date of preparation

Employer Group Name and Address	Return completed copies to:
	HIP HEALTH PLAN OF NEW YORK **ENROLLMENT DEPARTMENT** P.O. Box 2806 NEW YORK, NY 10116-2806

To be completed by employer or agent

1. HIP I.D. Number	2. Name of Subscriber Last	First	M.I.	3. Type of change or termination	4. Date of Effect change or termination	For HIP use only Contract Class Out 1	2	3	4	In 1	2	3	4	Remarks
			1											
			2											
			3											
			4											
			5											
			6											
			7											
			8											
			9											
			10											
			11											
			12											
			13											
			14											
			15											

For HIP use only – Summary of Decreases and Increases

Processed by	Effective date	In-Area contract class Out 1	2	3	In 1	2	3	Out-Area contract class Out 1	2	3	In 1	2	3	Premium Adjustments
Registrar														
Accounting														

Use the following codes to indicate type of transaction in Column 3

Change –	11=Increase in Coverage 16=Reinstatement - No Break in Coverage 18=COBRA 18 Months Coverage 30=Renewal with Break in Coverage 36=COBRA 36 Months Coverage	Termination –	67=Resignation of Subscriber from Group 71=Deceased 72=Member Non-Payment of Premium 80=Transfer to ANother Plan or Center
			84=Out of Service Area 85=Dissatisfied with Medical Service - Member 86=Dissatisfied with Medical Service - Group 87=Dissatisfied with HIP Administrative Services - Member 88=Dissatisfied with HIP Administrative Services - Group

16-0685