Employer Name _____ File # _____

Signature _____ Date Signed _____
Employer Representative completing this form

MERITAIN HEALTH

REPORT OF CHANGES

- Please be sure to sign. Unsigned change forms cannot be processed.
- Please notify Meritain Health promptly of terminations (limit of 30 days credit allowed).
- Send an application form for all new employees or additions of dependents.
- Include the address of terminated dependents.

		Termination of employee coverage			**Other changes** – including dependent deletions		**Meritain Health USE ONLY!**	
Print Employee Name and Address	Social Security Number	Last day worked	Reason for termination	Effective date of termination	**Requested change** Coverage change, Name/Address, Reduced hours, Student Status, Marital Status, Newborn	Requested effective date of change	Effective date of change	Date processed, & initials

Fax Transmittal Memo # Pages:

FOR PROMPT HANDLING PLEASE FAX	To: Matrix Insurance Marketing Fax: 206.521.9554	From: Company: Phone: Fax: Date:	Matrix Insurance Marketing, Inc. 1225 So. Weller Street, Suite 320 Seattle, WA 98144 Phone: 206.521.9451 Fax: 206.521.9554 Email: info@matrixinsurance.com