Enrollment / Change / Termination Form

INSTRUCTIONS: ***Please print clearly***

1. All sections MUST be completed.
2. This form MUST be signed and dated by an administrator at the group.
3. Please use the reason codes listed.
4. Please place a check in column for the coverage being enrolled/changed/terminated.

COMPLETE THIS FORM AND RETURN TO:

Capital Administrators
3819 Market Street
Camp Hill, PA 17011
Phone: (717) 975-9300
FAX: (717) 975-9303
EMAIL: crbadmin@crbenefits.net

Group Name:	**Date of Completion:**
Group Contact:	**Telephone Number:**
Group Contact Title:	**Email Address:**
Contact Signature:	

COMPLETE THIS SECTION FOR ENROLLMENTS AND CHANGES IN ENROLLMENT ONLY

Enrollment / Change Reason Codes:

1. New Hire
2. Change in Status (PTE-FTE)
3. Loss of Other Coverage
4. Life Status Change
5. Name/Address Change (provide new address in comments section)
6. Other (Denote in Comment Section)

Name (Last, First, MI)	Social Security Number	Date of Birth	Emp. Hire Date	Coverage Effective Date	Employee Class (if applicable)	Reason Code	Medical *	Dental *	Vision *	HRA or FSA	Life, STD, LTD *

** Please attach a copy of the carrier-specific enrollment form(s).*

COMPLETE THIS SECTION FOR TERMINATIONS ONLY

Termination Reason Codes:

7. Employment Terminated
8. Employee lost eligibility (reduction of hours)
9. Member Request (provide reason in comments section)
10. Non-payment of employee contribution

Name (Last, First, MI)	Social Security Number	Date of Birth	Emp. Term Date	Coverage Term Date		Reason Code	Medical	Dental	Vision	HRA or FSA	Life, STD, LTD

COMMENTS