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 –
- 57=Resignation of Subscriber from Group
- 71=Deceased
- 72=Member Non-Payment of Premium
- 80=Transfer to ANother Plan or Carrier
- 84=Out of Service Area
- 88=Dissatisfied with Medical Service - Member
- 94=Dissatisfied with Medical Service - Group
- 97=Dissatisfied with HIP Administrative Services - Member
- 98=Dissatisfied with HIP Administrative Services - Group