

KPS HEALTH PLANS GROUP TRANSMITTAL FORM – GROUP

GROUP IDENTIFICATION

Company Number:	Group Number:	Group Name:	
Prepared By:	Phone Number:	Date:	

IMPORTANT: SIGNED APPLICATION FORMS MUST BE ATTACHED FOR ADDITIONS AND CHANGES.

NEW SUBSCRIBERS

Social Security Number	Employee Name Last First	Tier	Date Of Hire Mo/Day/Yr	Probation Period (Days)	Intended Effective Date Mo/Day/Yr	Premium (+)

Total New Subscriber Premium (+): _____

SUBSCRIBER CANCELLATIONS (If elected, list subscribers only after TCC has been exhausted.)

Social Security Number (Or Subscriber ID #)	Employee Name Last First	Intended Effective Date Mo/Day/Yr	Reason	Premium (-)

Total Cancellations Premium (-): _____

CHANGES ON CURRENT SUBSCRIBERS

Social Security Number (Or Subscriber ID #)	Employee Name Last First	New Tier	Intended Effective Date Mo/Day/Yr	Reason (Code)	Old Premium	New Premium	Difference

Total Changes Premium (+/-): _____

Total Adjustments (Forward to adjustments line of premium bill): _____

CODES:

- | | |
|---|--|
| 1 Add new spouse (provide date of marriage) | 5 Add existing dependents (open season only) |
| 2 Add newborn or legally adopted child (provide date of event) | 6 Cancel spouse |
| 3 Add dependent per court order (provide copy of order) | 7 Cancel child(ren) |
| 4 Add dependent due to loss of other coverage (provide KPS waiver form and certificate of coverage from prior insurance carrier.) | 8 Cancel all dependents |
| 9 Other (please specify): _____ | |

TEMPORARY CONTINUATION OF COVERAGE (TCC) – Eligible group members have the option, upon termination, to continue coverage for a maximum of three months from date of qualifying events listed in the member contract. Employer is responsible to process any self-pay premium payment. No personal checks will be accepted. KPS Management 9/01/02