GROUP INSURANCE REPORTING FORM

Please use this form to report Employee Changes in Life Coverage and/or Terminations for Group Health plans.

COMPANY INFORMATION

Company Name	Group Plan ID

1. CHANGE IN LIFE COVERAGE *(Please tick if filling out this section)*

Please Indicate the Changes in Employee Salaries below

Employee Cert #	Employee Name	Current Salary	New Salary	Effective Date DD-MM-YYYY	Reason for Change

2. TERMINATIONS *(Please tick if filling out this section)*

Please List the Employees to be Terminated below

Employee Cert #	Employee Name	Date Employment Ceased DD-MM-YYYY	Month of Last Deduction	Reason for Termination

These changes will be reflected on the next billing once they are received by or before the 15th of the month.

Name of Employer / Plan Administrator Block Letters

Signature of Employer / Plan Administrator

Company Stamp And Date