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				**For HIP use only**								Remarks
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	Contract Class Out 1	Out 2	Out 3	Out 4	In 1	In 2	In 3	In 4	
	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	Out 2	Out 3	In 1	In 2	In 3	Out-Area contract class Out 1	Out 2	Out 3	In 1	In 2	In 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