



Northeast Delta Dental



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## NOTICE OF MEMBERSHIP CHANGES

PLEASE REFER TO THE REVERSE SIDE OF THIS FORM FOR IMPORTANT INSTRUCTIONS

ELIGIBILITY ORGANIZATION NAME MEDICAL GROUP / CARRIER NUMBER(S) DENTAL GROUP / CARRIER NUMBER(S)

KEY WORD (See Reverse)	NAME OF ENROLLEE <b>Please Print</b> (Last Name, First Name)	ENROLLEE Date of Birth	ACTUAL DATE OF EVENT*	EFFECTIVE OR TERMINATION DATE	MEMBERSHIP TYPE		Life	LTD	STD	FSA
					Medical	Dental				

Additional Comments:

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**NOTICE PREPARED BY:**

\_\_\_\_\_

Benefits Administrator Signature

Date: \_\_\_\_\_ Phone: \_\_\_\_\_

To be completed by Groups that have elected HealthTrust's retiree billing services			
	MEDICAL		DENTAL
	Retiree	Spouse	
Group Pays:			
Enrollee Pays:			
TOTAL:			

\* Enter the actual date the event occurred, e.g., the employee's last day of work, etc.

# INSTRUCTIONS AND EXPLANATION OF CODES FOR NOTICE OF MEMBERSHIP CHANGES (NOMC)

## KEY WORD

ADD COBRA	When an enrollee and covered dependent(s) have elected to continue coverage and have made their initial payment. For use by Groups who administer their own COBRA billing and collection.
REINSTATE COBRA	When an enrollee whose COBRA coverage has been cancelled (by not making payment by the due date) requests to reinstate COBRA coverage after making payment (within the 30-day grace period). For use by Groups who administer their own COBRA billing and collection.
CANCEL COBRA	For cancellation of COBRA coverage. Please specify “voluntary” or “non-payment.” For use by Groups who administer their own COBRA billing and collection.
LE-VOL	LEFT EMPLOYMENT-VOLUNTARY – When an enrollee is terminating employment voluntarily.
LE-INVOL	LEFT EMPLOYMENT-INVOLUNTARY – When an enrollee experiences an involuntary loss of employment or experiences and involuntary reduction in work hours.
VOL CANCEL	When an <b>enrollee requests voluntary cancellation</b> of coverage while still employed and eligible to remain covered. The NOMC must be received by HealthTrust <b>prior</b> to the requested cancel date. Request to voluntarily cancel Dental coverage may be done only at the Group’s open enrollment date. <b>Do not use this key word for termination of employment – use either LE-VOL or LE-INVOL.</b>
CANCEL-ACTIVE MILITARY DUTY	When an enrollee is cancelling due to leaving for active military duty.
DECEASED	This is applicable for the death of an enrollee. A <i>Medical and/or Dental Application and Change Form</i> must be completed for a deceased dependent. (NOTE: for NHRS retirees, a <i>Retirement Annuity Deduction Authorization for Medical and Dental Benefits</i> form is also required.)
RETIRED-CONTINUE	When an enrollee is retiring and is continuing the <b>same</b> coverage. If HealthTrust administers retiree billing services for the Group, the retiree’s billing allocation must also be provided to HealthTrust (see section on NOMC front). If the retiree is requesting a coverage change, a <i>Medical and/or Dental Application and Change Form</i> must be completed. (NOTE: for NHRS retirees, a <i>Retirement Annuity Deduction Authorization for Medical and Dental Benefits</i> form is also required.)
RETIRED DUE TO DISABILITY-CONTINUE	When an enrollee is retiring due to a disability and is continuing the same coverage. If HealthTrust administers retiree billing services for the Group, the retiree’s billing allocation must also be provided to HealthTrust (see section on NOMC front). If the retiree is requesting a coverage change, a <i>Medical and/or Dental Application and Change Form</i> must be completed. (NOTE: for NHRS retirees, a <i>Retirement Annuity Deduction Authorization for Medical and Dental Benefits</i> form is also required.)
RETIRED-CANCEL COVERAGE	When an enrollee is retiring and is <b>not</b> electing retiree coverage, and therefore, coverage is cancelled.
TRANSFER	Any transfer from section to section. If coverage is changing, a <i>Medical and/or Dental Application and Change Form</i> must be completed. If submitting a <i>Medical and/or Dental Application and Change Form</i> , do not also submit a NOMC.

## MEMBERSHIP TYPES

1 - Single (Employee only)

2 - 2-Person (Employee and spouse or employee and one dependent child)

3 - Family (Employee, spouse, child(ren))