



# GROUP MEMBERSHIP MAINTENANCE RECAP FORM

Anthem Blue Cross  
P.O. Box 629  
Woodland Hills, CA 91365

USE THIS FORM TO REPORT:

SECTION 1: New Enrollments/Terminations/Retroactivity

SECTION 2: Changes to Existing Contracts

SECTION 3: COBRA Enrollments/Terminations

*Please note: All retroactive requests are subject to review for approval.*

## SECTION 1: New Enrollments/Terminations/Retroactivity

(A completed and signed *Enrollment Application* must be attached for each enrollment request).

GROUP NAME:	
BILL ENTITY NUMBER:	PREPARED BY:
DATE:	TELEPHONE NUMBER:

GROUP NUMBER MEDICAL	GROUP NUMBER DENTAL	GROUP NUMBER LIFE	SUBSCRIBER CERTIFICATE NUMBER	SUBSCRIBER NAME	ADDITION/TERMINATION	EFFECTIVE DATE

Please complete and attach this form to all applicable Enrollment and Change forms. Please also retain a copy of this form for your records. Eligibility **changes received after the 5<sup>th</sup>** of the month may be reflected on your next bill. PLEASE DO NOT ADJUST THE TOTAL AMOUNT DUE ON YOUR CURRENT GROUP BILLING STATEMENT.

**SECTION 2: Changes to Existing Contracts**  
**(A completed and signed *Change* form must be attached).**

GROUP NUMBER MEDICAL	GROUP NUMBER DENTAL	GROUP NUMBER LIFE	SUBSCRIBER CERTIFICATE NUMBER	CURRENT CONTRACT TYPE*	NEW CONTRACT TYPE*	DEPENDENT NAME ADDITION/TERMINATION	EFFECTIVE DATE

**SECTION 3: COBRA Enrollments/Terminations**  
**(A completed and signed *Enrollment Application* must be attached for each enrollment request).**

GROUP NUMBER MEDICAL	GROUP NUMBER DENTAL	SUBSCRIBER CERTIFICATE NUMBER	SUBSCRIBER NAME	ADDITION/ TERMINATION	EFFECTIVE DATE

NOTES: (TO BE USED TO COMMUNICATE SPECIAL SITUATIONS)

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CONTRACT TYPE LEGEND	
S	Subscriber Only
2P	Two-Party Contract
FAM	Family Contract
DEP	One Dependent
DEPS	Two or More Dependents
S+DEP	Subscriber + 1 Dependent (No Spouse)

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