TUFTS Health Plan
No one does more to keep you healthy.

MEMBER CHANGE FORM

(Please see reverse side)

Please complete the summary and submit it with the applications and changes it reflects to:

TUFTS HEALTH PLAN
P.O. BOX 9186
WATERTOWN, MA 02471-9186
FAX 617-923-5898

Submitted By:	Date Submitted:	
Name of Employer Group:	Group Number:	Telephone Number:

1. Name of Member (Last, First, MI)	2. Member No.	3. Plan Code	4. Action Code	5. Effective Date	6. Additional Information
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PLEASE COMPLETE THE COLUMNS ON FRONT USING THE APPROPRIATE CODES AS LISTED BELOW:

Column	Heading	Description
1.	Member	Subscriber/Member Name (Last, First, MI)
2.	Member No.	Subscriber's Tufts Health Plan ID Number
3.	Plan Code	IND=Single FAM=Family FAM1=Subscriber+Children 2 PER=2 person 2SSP=Subscriber+Spouse 2SCH=Subscriber+Child
4.	Action Code	*Additions:* 101 New Hire 102 Open Enrollment/Special Open Enrollment 103 Dependent Addition 105 Reinstate-New Hire 106 Reinstate-Open Enroll 108 Cobra 109 COC *Changes:* 401 Change in Plan Code 407 Name/Address Change *Terminations/Involuntary* 350 Moved out of area 351 Reduction in work hours 352 Subscriber/Member died 353 Left Employ 357 Subscriber/Member age 65+ 358 Child over age not a student 359 Student over student age limit 360 Laid off more than 39 weeks 361 Dependent Child Married 362 Divorce 364 Student Graduated 366 Cobra eligibility has expired 377 COC eligibility has expired *Terminations/Voluntary* 301 Covered under another THP Policy 302 Transferred to other insurer 303 Subscriber premium not paid 304 Transferred to an HMO 305 Dissatisfied with plan
5.	Effective Date	Effective date of action (Addition, Change, Termination)
6.	Additional Information	Please comment or provide information on any aspect of this addition or change that you feel would be helpful