PLEASE USE THIS FORM TO UPDATE YOUR MEMBERSHIP

(When you are retroactively terminating coverage for your employees, you are allowed <u>TWO (2) months</u> plus the current month.)

GROUP NAME	GROUP NUMBER

Action Codes	Coverage Codes
A = Add employee	A = Family
T = Terminate employee	B = Employee plus one dependent (child or spouse)
X = Transfer (indicate the div#, class#)	C = Employee only, no dependents
C = Change (name change, coverage change, etc.)	D = Employee plus child(ren)
R = Reinstate employee	

Action Code	Member ID Number	Employee's Name Last, First	Division Number	Class Number	Coverage Code	Effective Date

Please fax this completed sheet to **877-654-3727.** Membership will be keyed in within one (1) business day of receipt. If additional forms are required, please contact VSP at the telephone number located on the first page of your billing statement. If you choose to fax your updates there is no need to mail the same updates. If you choose to mail your updates there is no need to fax.

Requestor Name_____ Date _____/_____/_____ Telephone (_____)_____-_____