HOPE TRUST
Health Options for Public Entities

FORM C

Membership Addition/Termination/Change Transmittal Form

EMPLOYER MUST FAX COMPLETED FORM to SRM (HOPE Trust Plan Administrator) at 309-543-6607

Employer Name: ______________________________

ADD NEW MEMBERS

(Employee must also complete separate ***EMPLOYEE FORM*** *; include when sending in this form.)*

Name	*Plan Choice (Major Medical, HRP, etc.)*	*Effective Date of Coverage*

TERMINATE EXISTING MEMBERS

Name	*Coverage Continuation Packet*		*Effective Date of Termination*
	Send COBRA	IMRF	
	YES / NO	YES / NO	
	YES / NO	YES / NO	

CHANGE COVERAGE OR ENROLLMENT INFO FOR EXISTING MEMBERS

(e.g., add newborn, add new spouse, change from Major Medical to HRP, change address, change last name, etc.)
(Employee may also need to complete separate ***EMPLOYEE FORM*** *; if so, include when sending in this form.)*

Present Name Under Plan	*Requested Change*	*Effective Date of Change*

______________________________ Signature of Employer Representative

______________________________ Date