SFI -212-539-0331

27573 F0230326

INSTRUCTIONS: PLEASE RETURN THE ORIGINAL COPY FORM TO GHI, SEE REVERSE SIDE FOR PROCEDURES REGARDING NEW ENROLLEES, REINSTATEMENT, TERMINATIONS AND OTHER CHANGES IN CONTRACT

HEALTH INSURANCE TRANSACTION FORM

GHI

P.O. BOX 2820
NEW YORK, N.Y. 10116-2820

CHECK BOX FOR APPLICABLE INSURANCE
- ☐ MEDICAL
- ☐ HOSPITAL
- ☐ DENTAL

A REASON(S) FOR SUBMISSION (CHECK ONE OR MORE BOXES)

- ☐ New Enrollment
- ☐ Reinstatement
- ☐ Termination
- ☐ Address Change
- ☐ Name Change
  Former Name _____
- ☐ **Change Contract to:** ☐ Individual ☐ Husband/Wife ☐ Parent & Child(ren) ☐ Family

TRANSFER
- ☐ To Another Carrier
- ☐ From GHI Group No. _____
- ☐ To GHI Group No. _____

CHANGE OF DEPENDENTS
- ☐ Add Spouse
- ☐ Delete Spouse
- ☐ Add Child(ren)
- ☐ Delete Child(ren)

B SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.	SEX ☐ MALE ☐ FEMALE

HOME ADDRESS	APT #	DATE OF BIRTH	EMPLOYMENT DATE

CITY	STATE	ZIP CODE	MARITAL STATUS - ☐ SINGLE ☐ MARRIED
			TYPE OF COVERAGE - ☐ INDIVIDUAL ☐ FAMILY ☐ HUSBAND/WIFE ☐ PARENT & CHILDREN

C DEPENDENT INFORMATION - List Below All Family Members to be Covered or Dropped

NAME (INDICATE DIFFERENT LAST NAME IF APPLICABLE)			DATE OF BIRTH	RELATIONSHIP	FULL TIME STUDENT	ADD	DELETE
LAST NAME	FIRST NAME	MI			Y or N	✔	✔

D SPOUSE INFORMATION - If spouse is to be Covered by Subscriber, PLEASE ANSWER THE FOLLOWING QUESTION

Does Spouse Have Own Health Coverage? ☐ Yes ☐ No If "Yes", Complete the Following Information

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO. (CERT. NO.)

EMPLOYMENT STATUS ☐ EMPLOYED ☐ NOT EMPLOYED ☐ RETIRED	SPOUSE'S HEALTH INSURANCE CARRIER INFORMATION	POLICY NUMBER	EFFECTIVE DATE

NAME OF SPOUSE'S EMPLOYER	NAME OF CARRIER
EMPLOYER'S ADDRESS	CARRIER'S ADDRESS

CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

E SUBSCRIBER SIGN BELOW

SUBSCRIBER SIGNATURE _____ DATE ___/___/___

GROUP AUTHORIZATION

AUTHORIZED SIGNATURE _____ DATE ___/___/___

F GROUP NAME AND ADDRESS

EFFECTIVE DATE OF TRANSACTION	GROUP NUMBER
MEDICAL	MEDICAL
HOSPITAL	HOSPITAL
DENTAL	DENTAL

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