



# HEALTH RESOURCES, INC.

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## NOTIFICATIONS TO HRI



1. Company Name Vanderburgh County  
Group Number 919910729200 Plan Number \_\_\_\_\_  
Benefits Manager \_\_\_\_\_ Phone Number \_\_\_\_\_

\* Subscriber terminating entire plan.

2a. **TERMINATION OF SUBSCRIBER COVERAGE.** HRI will credit only one month's premium after requested effective date. All additions should be reported through Subscriber Enrollment Applications.

Subscriber Name	SS#	Term Reason	Date Termed	Covered Through	Remarks

Termination Reasons: 1.) Employment Termination 2.) Reduction in hours 3.) Death 4.) Divorce 6.) Medicare 7.) Other \_\_\_\_\_

\* 2b. **TERMINATION OF DEPENDENT COVERAGE.** Terminating Dependents only.

Subscriber Name	SS#	Term Reason	Enrollee Name	Date Termed	Covered Through

Termination Reasons: 1) No longer FTS 2) Gained own coverage 3) Married 4) No longer dependent 5) Other (explain)

3. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 4. ADDRESS AND/OR NAME CHANGE.

Subscriber Name \_\_\_\_\_  
Former Address/Name: \_\_\_\_\_

SS# \_\_\_\_\_  
New Address/Name: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Signature of Benefits Manager \_\_\_\_\_ Date \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_