

## **IMPORTANT**

All Eligibility changes must be made using BluesEnroll, BluePrint for Employers, other electronic vendor, or paper enrollment/change forms. This form is only used to adjust your payment amount for this current bill

Group Na	me		Division#				P.O. Box 8069 Little Rock, AR 72203-8069		
							<u>hea</u>	lthadvantage-	nmo.com
	e if Chan	ge in Group Info	rmation						
Division Number	Action Code	Subscriber ID	Subscriber Name	Effect Date M / D / Y (for adds & changes only)	TERM Date M / D / Y (for terminations only)	Contract Type	DEDUCT From Bill	ADD To Bill	Net Change
A = Add Member D = Cancel Coverage C = Change in Contract type					Contract Type: EE = Employee Only ES = Employee/Spouse EC = Employee/Children FM = Family				
	Please a	nttach this Adj	ustment Form to	the Health Adva	ntage bill for t	he month	that is being	ı paid	
	F	Please Note: T	his is the preferr	ed method for su	bmitting adju	stments to	your bill		
<b>.</b>		News			2:	4			
<b>Group Adr</b> BILL-ADJ 09/18		r Name		Signature					