HOPETRUST
Health Options for Public Entities

FORM C

Must be Completed **ONLY IF** Employee is Making Changes
Due to the County Board Office 10/28/2022

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 Send* COBRA	IMRF	*Effective Date of Termination*
	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