American Specialty Health
Plans of California

Monthly Membership Change Report

1. **Employer must** submit a completed ASHP Application Form or a copy of the employee's Medical Enrollment Form **for all new hires and dependent additions**. When submitting a copy of the employee's Medical Enrollment Form, please note the type of coverage (single, double, or family) and the coverage effective date
2. Please sign and date the change form
3. Include the name of the employer

Social Security Number	Subscriber Name	Effective Date of Change	Add a new hire or dependent (Include the Enrollment Form) —OR— Delete a dependent, terminate an employee, COBRA, adjustment / revision	Premium Adjustment (+/-)

Signature: _____ *Date:* _____ *Employer Name:* _____

Please mail changes, terminations or additions only to: Contractor's Choice, 721 S. Parker, ste. 200, Orange CA 92868 or fax to 714-953-6987.