

**ACCOUNT TRANSMITTAL REPORT**

ACCOUNT NAME			ACCOUNT NUMBER	SUBMITTED BY:	PHONE NUMBER:	DATE SUBMITTED: / /	NUMBER OF APPLICATIONS SUBMITTED:	PAGE ____ OF ____
PLEASE CHECK ONE BOX			FIRST INITIAL AND LAST NAME ONLY	EFFECTIVE DATE Month / Day / Year	IDENTIFICATION NUMBER	CANCEL REASON CODE	COMMENTS (or Home Address for "Cancellations" with Reason Codes "D" and "LE" only)	
							Optional Use—BEGINNING CURRENT PREMIUM \$ _____	
							PREMIUMS DUE	
Add	Change	Cancel					+	-
			1.	/ /				
			2.	/ /				
			3.	/ /				
			4.	/ /				
			5.	/ /				
			6.	/ /				
			7.	/ /				
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			9.	/ /				
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			11.	/ /				
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			13.	/ /				
			14.	/ /				
			15.	/ /				

**Cancellation Reason Codes:**    **CR** = Customer Request    **D** = Deceased    **DC** = Duplicate Coverage    **LE** = Left Employment     Page Subtotal or  
**M** = Marriage    **MS** = Military Leave    **OP** = Transferred to other BCBS Co.     Total Amount Due \$ \_\_\_\_\_

This form serves as a record of **applications and cancellations** for your account. Complete an *Application for Coverage* form for any additions or changes in coverage. Send the completed original of this report with the accompanying applications. Retain a copy for your file. Mail this report as changes occur and **before the effective date to:**

Underwriting Department  
 Highmark Blue Cross Blue Shield Delaware  
 P.O. Box 8868  
 Wilmington, DE 19899-8868

*"As an authorized representative of the Company named below, I certify that all persons listed above are employees of the company as of this date, and that they and any enrolled dependents are eligible for coverage pursuant to the underwriting guidelines of Highmark Blue Cross Blue Shield Delaware."*

\_\_\_\_\_  
 Signature of Authorized Representative of the Company—**Not Valid Unless Signed**

\_\_\_\_\_  
 Name of Authorized Representative of the Company—**Please Type or Print**