



Group Control Form

See reverse side for mailing address

From (Name of Employer Group)

Submitted by (Signature)

Telephone Number

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Aetna U. S. Healthcare™ Group Number

Print Name of Authorized Employer Representative

Date

Name	Social Security Number	Member ID Number	Effective Date of Change	Deletions — Please List Reason(s) Please use appropriate code below; may use multiple codes	Comments
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

CHANGE CODES: C=Changed Health Plan, D=Death, DIS=Disability, ED=end of Dependency, L=Layoff, M=Medicare, R=Resignation, RH=Reduction in Hours,
 RI=Reinstatement, S=Student Status Change, T=Termination, TL=Transfer Location, DIV=Divorce or Legal Separation, O=Out of Service Area, N=Nonpayment