Attachment I

ELE TRANSMITTAL FORM

To Be Completed by CHPlus Health Plan		
CHPlus Health Plan Name:	**CHPlus Health Plan Contact Person** **Print Name: _____** **Signature: _____**	
Address:	**Form Transmittal Date:**	
CHPlus Health Plan Phone Number:	**Transmittal Form Sent To (Insert LDSS):**	
Children's Names in Section A	**Gender**	**End Date of CHPlus Coverage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		