COBRA Open Enrollment Form

Ameriflex

Company Name: ______________________ Date: ______________

Applicant Name (first, middle, last): ______________________

Member ID (which may be your SSN): ______________

Address: ______________________

City: __________ State: ________ Zip+4: ________ Tel: ________

Gender: M [ ] F [ ] DOB: ________ Marital Status: Single [ ] Married [ ]

HRA Enrolled: [ ] Email: ______________________

APPLICANT COVERAGE

Coverage: Add [ ] Remove [ ] Decline [ ] Keep Same [ ]

Plan Name: Medical ________ Dental ________ Vision ________ Rx ________

SPOUSE COVERAGE

Applicant Name (first, middle, last): ______________________

Address (if different from applicant): ______________________

City: ________ State: ______ Zip: ______ SSN: ________ DOB: ________

Coverage: Add [ ] Remove [ ] Decline [ ] Keep Same [ ]

Plan Name: Medical ________ Dental ________ Vision ________ Rx ________

DEPENDENT COVERAGE: Son [ ] Daughter [ ]

Applicant Name (first, middle, last): ______________________

Address (if different from applicant): ______________________

City: ________ State: ______ Zip: ______ SSN: ________ DOB: ________

Coverage: Add [ ] Remove [ ] Decline [ ] Keep Same [ ]

Plan Name: Medical ________ Dental ________ Vision ________ Rx ________

DEPENDENT COVERAGE: Son [ ] Daughter [ ]

Applicant Name (first, middle, last): ______________________

Address (if different from applicant): ______________________

City: ________ State: ______ Zip: ______ SSN: ________ DOB: ________

Coverage: Add [ ] Remove [ ] Decline [ ] Keep Same [ ]

Plan Name: Medical ________ Dental ________ Vision ________ Rx ________

I verify that the information given is true and correct.

Applicant Signature **Date**

Please mail or email: Ameriflex COBRA Department 2508 Highlander Way, Suite 200, Carrollton, TX 75006

Email: service@myameriflex.com