COBRA Request for Service

Ameriflex

Employer Name: _____

Participant Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

ADDRESS CHANGE IF APPLICABLE

New Address: _____

City: _____ State: _____ Zip: _____

Add/Drop Dependent (Check One): Add* ☐ Drop ☐

Dependent Name: _____

Dependent D.O.B.: _____ Relation to: _____

Reason for Add/Drop: _____

*Other than birth/legal adoption of a child by an enrolled COBRA participant, and a few other very rare exceptions, dependents may only be added during your employer's open enrollment period. If you are unsure, please contact AmeriFlex for further details.

If you are providing Medicare Eligibility documentation as requested, check YES: Yes ☐

(Must be accompanied by a photocopy of the Medicare ID card of the eligible person, showing Medicare eligibility date.)

Requesting Disability Extension (Conditions apply. Check one): Yes ☐

(Requests for Disability extension must be accompanied by a photocopy of Award Letter issued by the US Social Security Administration.)

Cancel/Drop Coverage(s) (Check all that apply):

Medical ☐ Rx (if separate from Medical) ☐ Dental ☐ Vision ☐ FSA ☐

Other: _____

All (cancel all COBRA coverage) ☐

Cancel/Drop Effective Date: _____ Reason: _____

Employee Signature **Date**

Send completed form to:

Ameriflex COBRA Department 7 Carnegie Plaza, Suite 200 Cherry Hill, NJ 08003

Fax: 609.257.0136

Email: cobra@myameriflex.com