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, fax, or email: Ameriflex COBRA Department 7 Carnegie Plaza, Suite 200, Cherry Hill, NJ 08003

Fax: 609.257.0136 **Email:** COBRA@myameriflex.com