COBRA Request for Service

Ameriflex

Participant Name: _____

Employer Name: _____

Date of Birth: _____ Member ID (or SSN): _____

Current/Previous Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Address Change If Applicable

New Street Address: _____

City: _____ State: _____ Zip: _____

Name Change If Applicable

New Name: _____

*Must include a copy of a legal document such as a marriage certificate or divorce decree.

Add/Drop Coverage: Please complete the following section if you would like to add or drop coverage.

Drop ALL coverage for primary as well as all dependents: Yes ☐ No ☐

Reason for Add/Drop: _____

If not dropping all family members' coverage, please indicate who should be dropped below.

Name: _____ Relation to QB: _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

Medical: Add ☐ Drop ☐ N/A ☐

RX (if separate from Medical): Add ☐ Drop ☐ N/A ☐

Dental: Add ☐ Drop ☐ N/A ☐

Vision: Add ☐ Drop ☐ N/A ☐

FSA/HRA: Add ☐ Drop ☐ N/A ☐

Other: _____ Add ☐ Drop ☐ N/A ☐

All Coverage: Add ☐ Drop ☐ N/A ☐

Reason for Add/Drop: _____

Name: _____ Relation to QB: _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

Medical: Add ☐ Drop ☐ N/A ☐

RX (if separate from Medical): Add ☐ Drop ☐ N/A ☐

Dental: Add ☐ Drop ☐ N/A ☐

Vision: Add ☐ Drop ☐ N/A ☐

FSA/HRA: Add ☐ Drop ☐ N/A ☐

Other: _____ Add ☐ Drop ☐ N/A ☐

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Vision: Add ☐ Drop ☐ N/A ☐

FSA/HRA: Add ☐ Drop ☐ N/A ☐

Other: _____ Add ☐ Drop ☐ N/A ☐

All Coverage: Add ☐ Drop ☐ N/A ☐

Reason for Add/Drop: _____

Please Note: To Add/Drop more than three family members, please complete a second form.

If you are adding a newborn, please include a copy of the Crib Card or any documentation from the hospital that shows the following:

Baby's Name • Date of Birth • Height • Weight

*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 the employer's open enrollment period. If you are unsure, please contact Ameriflex for further details.

Are you providing Medicare Eligibility documentation as requested? Yes ☐ No ☐
(Must be accompanied by a photocopy of the Medicare ID card of the eligible person, showing Medicare eligibility date.)

Are you Requesting a Disability Extension (Conditions apply)? Yes ☐ No ☐
(Requests for Disability extension must be accompanied by a photocopy of the Award Letter issued by the Social Security Administration.)

If you have paid premiums in advance and are not canceling all members and plans, your payment will be applied to future months' premiums for the plans with active enrollment. If you are paid in advance and if you are canceling all members and plans, a refund check will be mailed to the address that you listed on this form within 7-10 business days after your cancellation is processed.

Important: We **cannot** process cancellation requests dating back more than 30 days. Additionally, a request to cancel/drop coverage **can only be effective on the last day of a given month**. If you are requesting to cancel/drop coverage on any other day except for the final day of the month, **proof must be attached** to show the date that your alternate insurance coverage began or will begin.

Required. Effective Date of your requested changes:

Employee Signature

Date

Send completed form by email to:

service@myameriflex.com

Or by mail to:

Ameriflex COBRA Department

2508 Highlander Way - Suite 200
Carrollton, TX 75006