Special Plan Member Submission Form

Instructions

1. This form must be submitted within 30 days of the requested billing start date to ensure timley notification.
2. Complete one (*1*) form per Special Plan Member
3. Please confirm that this event has been accurately submitted and entered. Report any discrepancies immediately.

Employee Information

Company Name: _____ Date: _____

Your Name: _____ Email: _____

Special Plan Member Information

QB Name: _____
Salutation First Name MI Last Name

Address: _____ City: _____

State: _____ Zip+4: _____ Phone: _____ Email: _____

Gender: M ☐ F ☐ DOB: _____ SSN: _____ Individual ID: _____

Billing Information

Billing Type: Retiree ☐ Custom ☐ _____

Billing Start Date: _____ Original Enrollment Date: _____

Billing Frequencey: Monthly ☐ Weekly ☐ Bi-Weekly ☐ Quarterly ☐ Annually ☐

Special Plan Member Plans

Medical	EE ☐	EE+SP ☐	EE+CH ☐	EE+CHILDREN ☐	FAMILY ☐	EE+1 ☐	EE+2 ☐	Plan Name: _____
Dental	EE ☐	EE+SP ☐	EE+CH ☐	EE+CHILDREN ☐	FAMILY ☐	EE+1 ☐	EE+2 ☐	Plan Name: _____
Vision	EE ☐	EE+SP ☐	EE+CH ☐	EE+CHILDREN ☐	FAMILY ☐	EE+1 ☐	EE+2 ☐	Plan Name: _____
EAP	EE ☐	EE+SP ☐	EE+CH ☐	EE+CHILDREN ☐	FAMILY ☐	EE+1 ☐	EE+2 ☐	Plan Name: _____
Pharmacy	EE ☐	EE+SP ☐	EE+CH ☐	EE+CHILDREN ☐	FAMILY ☐	EE+1 ☐	EE+2 ☐	Plan Name: _____

Flex Monthly Contribution: _____ Other: _____

Dependent Information

Spouse: _____ SSN: _____ Gender: M ☐ F ☐ DOB: _____ Enrolled: _____

Child: _____ SSN: _____ Gender: M ☐ F ☐ DOB: _____ Enrolled: _____

Child: _____ SSN: _____ Gender: M ☐ F ☐ DOB: _____ Enrolled: _____

Child: _____ SSN: _____ Gender: M ☐ F ☐ DOB: _____ Enrolled: _____

Address if different from QB: _____

Send mail, email, or fax completed form to:

Ameriflex 7 Carnegie Plaza, Suite 200, Cherry Hill, NJ 08003 Attn: COBRA Department
Email: COBRA@myameriflex.com **Fax:** 609.257.0136