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 7 Carnegie Plaza, Suite 200, Cherry Hill, NJ 08003

Email: service@myameriflex.com