

## ENROLLMENT CHANGE FORM

COBRA PARTICIPANT NAME: LAST, FIRST, MI.			SOCIAL SECURITY NUMBER
<input type="checkbox"/> <b>Check if name change</b>			
STREET ADDRESS			HOME PHONE
CITY	STATE	ZIP	FORMER EMPLOYER NAME
DOB (MM/DD/YY)			

Please check box if new address

**ADD**

**BIRTH/ADOPT**       **MOVED OUT OF AREA**       **TURNING BENEFITS OVER TO SPOUSE/DEPENDENT**

**REASON:**

**CARRIER/PLAN:** \_\_\_\_\_

	DOB (MM/DD/YY)	SS#	<b>CIRCLE:</b> MEDICAL DENTAL VISION	<b>EFFECTIVE DATE:</b> MM/DD/YY
SELF				
SPOUSE				
CHILD				

**REMOVE**

**DROP COVERGE/DEPENDENT(S)**       **MOVED OUT OF AREA**       **TURNING BENEFITS OVER TO SPOUSE/DEPENDENT**       **ACQUIRED OTHER COVERAGE**

**REASON:**

**CARRIER/PLAN:** \_\_\_\_\_

	DOB (MM/DD/YY)	SS#	<b>CIRCLE:</b> MEDICAL DENTAL VISION	<b>EFFECTIVE DATE:</b> MM/DD/YY
SELF				
SPOUSE				
CHILD				

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

*I represent that all information supplied in this application is true and complete.*

*Please sign and return this form to:*

**Planned Benefit Systems, Inc.**  
**Attn: COBRA Compliance Department**  
**P.O. Box 4594**  
**Greenwood Village, CO 80155-4594**

**OR Fax: 303.221.2785**  
**Email: COBRA@pbs.us.com**