

# TAXSAVER PLAN

"Your Satisfaction Is Our Success"

Fax to: 214-528-8122  
 Email to: [cobra@taxsaverplan.com](mailto:cobra@taxsaverplan.com)  
 PO Box 609002  
 Dallas, TX 75360  
[www.taxsaverplan.com](http://www.taxsaverplan.com)

To: Rachel /Jenn N/ Jenn R/ Dory/ Amy B. From:

(Please circle one)

Phone/Email:

Date:

Please complete the following information:

<b><u>New Plan Member</u></b>	<b><u>Qualified Beneficiary</u></b>
Employee Name:	Employee Name:
Employee SSN:	Employee SSN:
Employee Address:	Employee Address:
Employee DOB:	Employee DOB:
Employee Hire Date:	Employee Hire Date:
	Employee/Dependent Event Date:
	COBRA Qualified Event:: Involuntary Term                      Voluntary Term Reduction in Hours                      Retirement Divorce                                      Child reached age limit Death    Medicare Reduction in Hours – end of leave
	Coverage in place at time of event – please circle MEDICAL              DENTAL              VISION              FSA
	Name of plan required if more than 1 plan offered for coverage:
	Level of Coverage – please circle one EE              EE+ spouse              EE+ child              EE+children              Family
	List Dependents Covered by name, SSN and DOB: