

TAXSAVER PLAN

"Your Satisfaction Is Our Success"

REQUEST TO CHANGE COBRA COVERAGE UNDER THE _____ GROUP PLAN

COBRA participant name: _____

COBRA participant SSN: _____

(or last 4 digits)

Effective Date: _____

Please state the reason that you are requesting a change in your existing COBRA coverage:

Dependent(s) you elect to drop:

_____ Spouse _____ Dependents – please list by name:

Coverage you wish to change:

_____ Medical _____ Dental _____ Vision

_____ Other – please write in: _____