

TAXSAVER PLAN

"Your Satisfaction Is Our Success"

Remit to:
214-528-8122 – fax
cobra@taxsaverplan.com

REQUEST TO CHANGE/ADD/DROP 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:

_____ Self _____ Spouse _____ Dependents – please list
by name:

Coverage you wish to change:

_____ Medical _____ Dental _____ Vision
_____ Other – please write in: _____

_____ Drop All Coverage

Signature Line: _____