TAXSAVER PLAN

"Your Satisfaction Is Our Success"

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

REQUEST TO CHANGE/ADD/DROP COBRA COVERAGE UNDER THE
_____(name your prior employer here) 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 or add:

_____Self _____ Spouse _____ Dependents

Please include name and SSN of Spouse/Dependents you are adding or dropping coverage for.

NAME: SSN: DOB:

_____

_____

_____

_____

_____

Coverage you wish to change:

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

_____ Drop All Coverage

Signature Line: _____