Instructions for Form Completion:
Please complete, sign and return the COBRA Request for Change Form to: Fax: 214-528-8122
Email:csr@taxsaverplan.com
Mail: PO Box 609002 Dallas, TX 75360
Forms will be reviewed and processed within 3 -5 days.

Reasons to submit this form: Request to add a new dependent or self to COBRA Coverage: A dependent may add coverage in the following circumstances: Marriage, Birth or Adoption. The dependent must be added within 60 days of one of these 3 events. The effective date of the change will be the date of the event. If you have a dependent that was eligible for COBRA at the time of your COBRA qualified event and they have lost coverage while you have been on COBRA, it is possible to add them back on your COBRA coverage. We may request additional documentation other than this completed form to add the coverage.

HIPAA Special Enrollment Rights: If you experience a Marriage, Birth or Adoption event and wish to add your qualified dependent within the 60 day window mentioned above, you may also choose to elect a different plan offered under your previous Employer's benefit options. As an example, if the Qualified Beneficiary is enrolled in the COBRA HDHP Plan and, due to a Birth event, adds the new dependent (child) within 60days, the Qualified Beneficiary may choose to move to the PPO Plan at that time, as long as the applicable premiums are paid for the coverage newly elected.

Request to drop a dependent or self from COBRA Coverage: A dependent may drop coverage with the completion of this form. The effective date of the change will be the first of the following month. Only prospective changes are allowed. If the reason for the request to drop coverage is due to the death of the former employee or divorce from the former employee or loss of dependent status, please indicate on the form to ensure the event is processed as a Second Qualified Event when applicable and include a copy of the Divorce Decree.

Voluntary request to drop COBRA Coverage: You may request to voluntarily drop your COBRA Coverage at any time during the period of COBRA Coverage and coverage will be terminated. Please note that if a payment has been received for the given month, it will not be refunded to you and coverage will terminate on the last of day of the month you have paid through. Please also note that any services incurred after your last day of coverage that are submitted to the insurance carriers for payment will be your responsibility if you have exhausted your coverage or requested to drop your coverage or not paid in full for your coverage in a given month. Change forms received after the 5thof the month will be effective the first of the following month. Premium payments are still required until the effective date of the change.

Medicare Entitlement: If at any point in time a Qualified Beneficiary, while covered under COBRA, becomes eligible and enrolled in Medicare, TaxSaver Plan should be notified. COBRA Medical coverage for the person enrolled in Medicare will terminate. Benefits for any other COBRA Qualified Beneficiaries will remain intact for the remainder of the maximum coverage period, assuming timely payments are made for the cost of coverage.

REQUEST TO CHANGE -- ADD -- DROP (please circle one) COBRA COVERAGE UNDER THE

_____(name your prior employer here) PLAN:

COBRA participant name: _____

COBRA participant SSN: _____ (or last 4 digits)

Date Submitted: _____

Effective Date: _____ - THIS FIELD IS REQUIRED

PLEASE NOTE THAT A REQUEST TO CANCEL COVERAGE IS A PROSPECTIVE REQUEST. IF CANCELLATION IS NOT REQUESTED BY THE 5TH OF THE MONTH YOU AND YOUR DEPENDENTS WILL BE COVERED FOR THE REMAINDER OF THE CURRENT MONTH AND FULL PAYMENT OF PREMIUM IS REQUIRED.

IMPORTANTNOTE:
Insurance Company processing of your cancellation effective date may take up to 10 business days.

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

_____ Drop/Cancel ***All Coverage***

Signature Line: _____

Date: _____ Contact Info (phone or email address): _____