Instructions for Form Completion:

Please complete, sign and return the COBRA Change Request Form to:

Fax: 214-528-8122
Email:csr@taxsaverplan.com
Mail: PO Box 609002 Dallas, TX 75360
Forms must be signed by the Primary Qualified Beneficiary (PQB) and will be reviewed and processed within 3 -5 days.

Reasons to submit this form:

Request to add a new dependent to COBRA Coverage: A PQB may request to add a dependent to COBRA under 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. Proof of marriage, birth or adoption is required to add a new dependent.

Request to drop a dependent or self from COBRA Coverage: A PQB may elect to drop a dependent from COBRA coverage. The effective date of the change will be the first of the following month, in most instances. Usually, only prospective changes are allowed. The affected spouse must also sign this form. 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.

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

Voluntary request to drop COBRA Coverage: A PQB may request to voluntarily drop 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 month, it will not be refunded and coverage will terminate on the last of day of the month paid through. Please also note that any services incurred after the last day of COBRA coverage that are submitted to the insurance carriers for payment will be the responsibility of the PQB if coverage has been exhausted/terminated or if the PQB requested to drop coverage and not paid in full for the month. Change forms received after the 5th of 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 Primary Qualified Beneficiary, while covered under COBRA, becomes entitled and/or 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.

<u>IMPORTANT NOTE</u>: 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:

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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 below.

NAME: **SSN:** **DOB:**

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Coverage you wish to change:

_______Medical ________ Dental ________Vision ________Other

___________ Drop/Cancel ***All Coverage***

Primary Qualified Beneficiary Signature Line: ____

Spouse Signature Line (required when changing spouse coverage):____

Date: _________________ **Contact Info (phone or email address):** ____