



COBRA Status Change Form

Fax your completed form to FlexAmerica at 301-530-3295 or email to cobrasupport@flexamerica.com. FlexAmerica will process your change and mail applicable correspondence (termination notice, new payment coupons, etc.).

1. Enter the following information (please print clearly).

Former Employer: _____

Name _____

Social Security Number _____

Street Address: _____

City, State, ZIP: _____

Phone: _____

E-mail: _____

2. Check the reason for the change.

- Optional termination of ALL COBRA coverage
Payment overages can be refunded only if we receive your request within the same month that you are requesting to terminate coverage (for example, if you terminate COBRA effective 11/1, we must receive your form by close of business 11/30).
- Optional termination of one or more benefit plans
No refunds are processed; a payment adjustment is applied to your account.
- Birth or adoption of dependent
- Death of dependent
- Divorce or legal separation
Attach copy of Final Separation/Divorce Decree
- Overage dependent lost coverage
- Medicare entitlement
FlexAmerica will cancel your COBRA coverage and send COBRA qualifying event notices to your covered dependents.
- Overage dependent has become a full-time student
- SSA-certified disability (seeking 11-month extension)
Attach copy of Notice of Award from Social Security Administration.
- Address change
- Other

3. Enter the effective date of the change: _____

(Enter date of event for birth or adoption. For all other changes, enter 1st of month following date of event. For terminations, enter 1st day of month following last month of coverage.)

4. Enter your requested COVERAGE change:

Benefit Plan (Medical, Dental, Vision, etc.)	Requested Change	OLD Coverage Level (Single, Single + Spouse, Family, etc.)	NEW Coverage Level (Single, Single + Spouse, Family, etc.)
	Change coverage level / Drop plan		
	Change coverage level / Drop plan		
	Change coverage level / Drop plan		

5. Enter your DEPENDENT change: (ALL fields are required; omissions will delay processing)

Add / Drop Dependent?	IF DROPPING, was dependent covered when you elected COBRA?	Dependent Name	Social Sec Number	Date of Birth	Relationship (Spouse, Child, etc.)	Benefit Plan Coverage (Medical, Dental, Vision, etc.)
Add / Drop	Yes No					
Add / Drop	Yes No					
Add / Drop	Yes No					

6. Participant: Read the following and sign / date.

I certify that the information I have provided is true and correct, and I agree to provide any necessary documentation, if requested, to verify my change in status.

Participant Signature _____ Date _____