Form for Switching COBRA Continuation Coverage Benefit Options

IF YOUR EMPLOYER WILL ALLOW A PLAN CHANGE FOR THE SUBSIDIZED PERIOD COMPLETE THE FOLLOWING

Instructions: To change the benefit option(s) for your COBRA continuation coverage to something different than what you or the participating employee had on the last day of coverage, complete this form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options.

Send completed form to: [*Enter Name and Address*]

This form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

THIS IS NOT YOUR ELECTION NOTICE
YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE TO SECURE YOUR COBRA CONTINUATION COVERAGE.

I (We) would like to change the COBRA continuation coverage option(s) in the [*enter name of plan*] (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

Old Coverage Option: _____

New Coverage Option: _____

b. _____

Old Coverage Option: _____

New Coverage Option: _____

c. _____

Old Coverage Option: _____

New Coverage Option: _____

_____ _____
Signature Date

_____ _____
Print Name / Relationship to individual(s) above

_____

_____

_____ _____
Print Address Telephone number