



MONGOOSE®

NEW PLAN MEMBER
GENERAL RIGHTS NOTIFICATION



Please mail, fax, or email to:
AMERIFLEX
302 Fellowship Road, Suite 100
Mount Laurel, NJ 08054
Attn: COBRA Department
E-mail: COBRA@flex125.com
Phone: 888-868-3539
Fax: 609.257.0136

Instructions:

1. Complete one (1) form per new plan member.
2. Please confirm this event has been accurately submitted and entered.
3. Report any discrepancies immediately.

Employer Information

Company Name: _____ Date: _____
Your Name: _____ Email: _____

Employee Information

Name: _____
Salutation First Name MI Last Name
 SSN: _____ Individual ID: _____ Email: _____
 Address: _____
 City: _____ State: _____ Zip + 4: _____ Phone: _____
 Gender: M F DOB: _____ Wavied All Coverage: Y N

Please check all plans that the New Plan Member is enrolling in

Medical EE EE+SP EE+CH EE+CHILDREN FAMILY EE+1 EE+2 Plan Name: _____
 Dental EE EE+SP EE+CH EE+CHILDREN FAMILY EE+1 EE+2 Plan Name: _____
 Vision EE EE+SP EE+CH EE+CHILDREN FAMILY EE+1 EE+2 Plan Name: _____
 EAP EE EE+SP EE+CH EE+CHILDREN FAMILY EE+1 EE+2 Plan Name: _____
 FLEX Monthly Contribution: _____ Other: _____