



COBRA

OPEN ENROLLMENT FORM



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

Company Name: _____ Date: _____

Applicant Name: _____
First Name MI Last Name

SSN: _____ Email: _____

Address: _____

City: _____ State: _____ Zip+4: _____ Phone: _____

Gender: M F DOB: _____ Marital Status: Single Married HRA Enrolled:

Applicant Coverage

Coverage: Add Remove Decline Keep Same

Plan Name: Medical _____ Dental _____ Vision _____ RX _____

Spouse Coverage

Name: _____
First Name MI Last Name

Address (if different than Applicant): _____

City: _____ State: _____ Zip: _____ SSN: _____ DOB: _____

Coverage: Add Remove Decline Keep Same

Plan Name: Medical _____ Dental _____ Vision _____ RX _____

Dependent Coverage Son Daughter

Name: _____
First Name MI Last Name

Address (if different than Applicant): _____

City: _____ State: _____ Zip: _____ SSN: _____ DOB: _____

Coverage: Add Remove Decline Keep Same

Plan Name: Medical _____ Dental _____ Vision _____ RX _____

Dependent Coverage Son Daughter

Name: _____
First Name MI Last Name

Address (if different than Applicant): _____

City: _____ State: _____ Zip: _____ SSN: _____ DOB: _____

Coverage: Add Remove Decline Keep Same

Plan Name: Medical _____ Dental _____ Vision _____ RX _____

I verify that the information given is true and correct.

Applicant Signature: _____