



# COBRA

## OPEN ENROLLMENT FORM



Please mail, fax, or email to:

**AMERIFLEX**

700 East Gate Drive, Suite 510  
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: \_\_\_\_\_