COBRA CHANGE FORM

FORMER EMPLOYER NAME: _____

PQB / EMPLOYEE NAME: _____ **SS#:** _____

ADDRESS: _____ **PHONE#:** _____

I have experienced the following change within the last 30 days and I wish to add to, change or cancel my existing benefit.

CHECK APPROPIATE BOX FOR CHANGE	**DATE CHANGE OCCURRED**
❑ Marriage or Divorce	_____
❑ Death of spouse or dependent	_____
❑ Birth or Adoption of a child	_____
❑ Terminate COBRA coverage	_____
❑ Other: _____	_____

INDICATE REQUESTED CHANGE

Add	Delete	Last Name, First Name	Date of Birth	SS#	Benefit
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				

I understand that this change form must be presented to National Plan Administrators, Inc. within 30 days of the eligible event, or no changes will be made. I also understand that if there is an interruption of monthly payments my coverage will be terminated. I further understand that this change will become effective the first of the month following the qualified event date. I certify that the above information is true and correct to the best of my knowledge.

_____ _____

PQB / Employee Signature Date

For Administrators Use Only

- ❑ Accepted (new election form sent _____)
- ❑ Rejected (letter sent explaining reasons why)
- ❑ Need more information (letter sent requesting more)

_____

Representative Signature Date

NATIONAL PLAN ADMINISTRATORS
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