

**REQUEST FOR COBRA COVERAGE
CHANGE IN BENEFIT ELECTION**

PART 1 – COBRA PARTICIPANT *(Must Be Completed – Please Print)*

COBRA Participant's Name _____ Social Security Number _____ - _____ - _____
 Home Address _____ Former Employer _____
 City/State/Zip _____ Daytime Telephone (_____) _____ - _____
 E-Mail Address _____

PART 2 – STATUS CHANGE *(YOU, YOUR SPOUSE, OR DEPENDENT MUST HAVE EXPERIENCED ONE OF THE FOLLOWING STATUS CHANGES WITHIN THE PAST 30 DAYS)*

<i>Status Change (check one)</i>	<i>Date of Status Change</i>	<i>Name and Relationship of Person Experiencing Status Change</i>	<i>Documentation You Must Attach With This Request</i>
<input type="checkbox"/> Marriage			Copy of Marriage License
<input type="checkbox"/> Divorce			Copy of Divorce Decree
<input type="checkbox"/> Legal Separation/Annulment			Copy of Court Order
<input type="checkbox"/> Birth			Copy of Birth Certificate
<input type="checkbox"/> Adoption			Copy of Adoption Papers
<input type="checkbox"/> Gain or Loss of Custody			Copy of Custody Agreement
<input type="checkbox"/> Death of Spouse or Dependent			Copy of Death Certificate
<input type="checkbox"/> Move Out of Coverage Area			Address Change Notice
<input type="checkbox"/> Change in Employment Status			Letter from Employer
<input type="checkbox"/> Gained New Employment with Coverage			Copy of Termination Notice
<input type="checkbox"/> Retirement of Spouse			Letter from Employer
<input type="checkbox"/> Medicare Eligibility			Copy of Medicare Card
<input type="checkbox"/> Loss of Dependent's Eligibility <i>(due to age or student status)</i>			Copy of Birth Certificate

PART 3 – DESIRED CHANGE *(YOUR REQUEST MUST BE APPROPRIATE AND CONSISTENT WITH THE STATUS CHANGE YOU CHECKED ABOVE)*

<i>Check All That Apply</i>	<i>Change From</i>	<i>Change To</i>	<i>Check All That Apply</i>	<i>Change From</i>	<i>Change To</i>
<input type="checkbox"/> Group Medical Insurance			<input type="checkbox"/> Other (Describe)		
<input type="checkbox"/> Group Dental Coverage			<input type="checkbox"/>		
<input type="checkbox"/> Group Vision Coverage			<input type="checkbox"/>		
<input type="checkbox"/> Medical Spending Account			<input type="checkbox"/>		

PART 4 – EMPLOYEE'S SIGNATURE *(Required)*

I certify that the information provided on this Application is accurate and correct, and that I have attached the documentation required to substantiate the status change indicated above. I further understand that, if approved my election change will not be effective retroactively but will become effective on the first of the following month of the date of approval. I also understand this change will effect my current rates.

X _____ Date _____

Return this form to EBS/Atlanta, 2500 Northwinds Parkway, Alpharetta, GA 30009 or fax to 770-569-0211 _____ If you need assistance, please call 1-800-647-3709 or email cobra@ebsatlanta.com

FOR ADMINISTRATIVE USE ONLY

Recommendation: For Approval For Denial By: _____ for EBS/Atlanta Date: _____
 Recommendation: Accepted Rejected By: _____ for Employer Date: _____