

## COBRA Change Form

COBRA participant name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_

Date: \_\_\_\_\_

Contact Number: \_\_\_\_\_

### Option I:

- I, \_\_\_\_\_, would like to cancel my ACH withdrawal for my monthly COBRA premiums. I understand that I cannot cancel any withdrawals retroactively. I also understand that I must notify Consociate at least 10 business days in advance in order to be processed as requested.

### Option II:

- I, \_\_\_\_\_, would like to cancel all of my COBRA Continuation Coverage benefits.

### Option III:

- I, \_\_\_\_\_, would like to cancel my **Medical, Dental, Vision** COBRA Continuation Coverage benefit, (Circle what you would like to cancel).

**\*\*Please note that coverage cannot be cancelled retroactively for any benefits. Notice must be given at least 10 business days in advance of the requested Effective Date.\*\***

Effective Date of Change: \_\_\_\_\_

Signature of COBRA participant: \_\_\_\_\_

Date: \_\_\_\_\_

### Please submit this to:

P.O. Box 1068

Decatur, Illinois 62525

**217.422.9224** (fax)

or scan and email to:

**customerservice@consociate.com**