CONSOCIATE HEALTH

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:

eligibilityrt@consociate.com