Please return this form to Flex Facts; 7 Grant Avenue, Lakewood, NJ 08701
Fax: 877-747-8564, E-mail; COBRA@flexfacts.com;

COBRA Open Enrollment Form

Employer: _____

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: **( )** _____ Alternate Phone: **( )** _____

E-mail Address: _____ Social Security Number: _____

Gender: _____ DOB: _____ Marital Status: _____

Applicant Coverage

Coverage: Add ☐ **Remove** ☐ **Decline** ☐ **Keep Same** ☐

Plan Name: **Medical** **Dental** **Vision** **Rx**

Spouse Coverage

Spouse Name: _____
Last *First* *M.I.*

Address: _____
If different than applicant *Street Address* *Apartment/Unit #*

_____
City *State* *ZIP Code*

Coverage: Add ☐ **Remove** ☐ **Decline** ☐ **Keep Same** ☐

Plan Name: **Medical** **Dental** **Vision** **Rx**

Dependent Coverage

Spouse Name: _____
Last *First* *M.I.*

Address: _____
If different than applicant *Street Address* *Apartment/Unit #*

_____
City *State* *ZIP Code*

Coverage: Add ☐ **Remove** ☐ **Decline** ☐ **Keep Same** ☐

Plan Name: **Medical** **Dental** **Vision** **Rx**

I verify that the information given is true and correct:

Signature: _____