**COBRA OPEN ENROLLMENT FORM**

 **Effective August 1, 2022**

**Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name , First Name** | **Social Security Number** | **Plan Options** **Medical Plans (check one)****🞏 Aetna HMO**® **(CA only)** | **COBRA Coverage Includes:****🞏 Employee Only** **🞏 Employee & Dependent(s)**  |
| **Address (street, city, state, zip)** | **Date of Birth** | **🞏 Aetna POS****🞏 Aetna Basic PPO** **Dental Plans (check one)****🞏 Aetna DMO**®**🞏 Aetna PPO** | **🞏 Dependents Only** **If Enrollee is not (former) employee:** |
| **Home Phone** | **Email** | **🞏 Vision Service Plan****🞏 No changes, I want to keep my current coverage.** | **Employee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Employee SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­** |

**Individual Information (check box for coverage)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Last Name , First Name** | **SSN** | **DOB** | **Sex****M/F** | **Relation to Employee** |  **Medical** | **For HMO only**  **Current**  **Doctor #[[1]](#footnote-1) Y/N**  | **Denta**l | **For DMO only** **Dentist #1** | **Vision** |
|  |  |  |  | **SELF** | 🞏 |  |  | 🞏 |  | 🞏 |
|  |  |  |  |  | 🞏 |  |  | 🞏 |  | 🞏 |
|  |  |  |  |  | 🞏 |  |  | 🞏 |  | 🞏 |

**Upload this form by July 15, 2022 via the SECURE WEB LINK FOR EMPLOYEE FORMS (**[**https://tpbenefits.com/forms**](https://tpbenefits.com/forms)**)** **posted at** [**tpbenefits.com**](https://tpbenefits.com/)**.**

**AUTHORIZATION (Required)**

I hereby state that I understand that the election(s) I make cannot be changed until the next Open Enrollment period. I further state that all information furnished is true and complete to the best of my knowledge and I authorize the carrier or agent to obtain medical records and information from providers relating to me and my eligible dependents, to the extent required to provide administrative services in connection with the plans.

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 **Signature Date**

**For Office Use Only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of Qualifying Event** | **Date of Loss of Coverage** | **Date COBRA Coverage Ends** | **Date Notice Given** | **Production** |
|  |  |  |  |  |
| Plan Administrator Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Khuyen Phan, Benefits Manager |

1. use [Provider Search](https://tpbenefits.com/s/provider-search.pdf) to find provider ID# [↑](#footnote-ref-1)