COBRA OPEN ENROLLMENT FORM
Effective August 1, 2020

Employee Information

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

Individual Information (check box for coverage)

Last Name , First Name	SSN	DOB	Sex M/F	Relation to Employee	Medical	For HMO only Doctor #[1]	Current Y/N	Dental	For DMO only Dentist #[1]	Vision
				self	☐			☐		☐
					☐			☐		☐
					☐			☐		☐

Upload this form by July 17, 2020 via SECURE WEB LINK FOR EMPLOYEE FORMS posted at 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.

_____

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

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Khuyen Phan, Benefits Manager

[1] use Provider Search to find provider ID#