COBRA Change Form

This form must be completed and returned to the PEBTF to report the addition or deletion of a qualified dependent or to request a voluntary termination of your COBRA coverage. The addition of a dependent may only be made on a prospective basis.

COBRA Member Data

This Section to be Completed For Any Requested Change

Subscriber Name _____ Social Security # _____

Street Address _____ City, State, Zip Code _____

The Following Changes Are Being Requested

Terminate my coverage: ☐ Prescription Drug ☐ Supplemental ☐ Medical ☐ Medical & Supplemental

Effective: _____

Terminate coverage for the following dependent(s) effective: _____

☐ Prescription Drug ☐ Supplemental ☐ Medical ☐ Medical & Supplemental

Dependent Name _____ Social Security # _____ Reason (death, divorce, other coverage) _____

Dependent Name _____ Social Security # _____ Reason (death, divorce, other coverage) _____

Add coverage for the following dependent(s) effective: _____

☐ Prescription Drug ☐ Supplemental ☐ Medical ☐ Medical & Supplemental

Dependent Name _____ Social Security # _____ Relationship _____ Date of Birth _____

Dependent Name _____ Social Security # _____ Relationship _____ Date of Birth _____

YOU MUST COMPLETE THIS SECTION TO AUTHORIZE ANY CHANGES

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ON THIS FORM IS ACCURATE.

Signature _____ **Signature Date** _____

Mail Completed Form to:

PEBTF
150 South 43rd St., Suite 1
Harrisburg, PA 17111-5700

PEBTF