Benefit Advantage
Mail: PO BOX 5545 DePere, WI 54115-5545
Phone: (800) 686-6829
Fax: (920) 339-0038

PLEASE PROVIDE THE FOLLOWING INFORMATION TO ENROLL AN *EXISTING* COBRA PARTICIPANT:

COMPANY NAME: _____

Last Name **First** **MI** **Social Security #**

Street **D.O.B.** **Sex**

City **State** **Zip** **Telephone Number**

Email: _____

Qualifying Event Reason (X one): ☐ Involuntary Termination, ☐ Voluntary Termination, ☐ Divorce, ☐ Associate's Death, ☐ Reached Dependent Age Limit, ☐ Reduced Hours, ☐ Retirement,
Other: _____

Qualifying Event Date: _____

COBRA Start Date: _____

Information on Dependents (Spouse and/or Children)

Last Name	**First**	**D.O.B.**	**SS#**	**Relationship**
Last Name	**First**	**D.O.B.**	**SS#**	**Relationship**
Last Name	**First**	**D.O.B.**	**SS#**	**Relationship**

Current Benefit Plan/s: _____

Single _____ Limited Family _____ Family _____

Premium paid through date: _____

Original Health Insurance Start Date: _____

FAX to: COBRA Dept. 920-339-0038