2025 CHARLES DREW UNIVERSITY COBRA OPEN ENROLLMENT FORM

SECTION 1: ELECTION OF BENEFITS

KAISER HMO:	☐ Participant Only	☐ Participant + Spouse	☐ Participant + Child	☐ Participant + Children	☐ Family
AETNA HMO:	☐ Participant Only	☐ Participant + Spouse	☐ Participant + Child	☐ Participant + Children	☐ Family
AETNA OAMC:	☐ Participant Only	☐ Participant + Spouse	☐ Participant + Child	☐ Participant + Children	☐ Family
DELTA DENTAL HMO:	☐ Participant Only	☐ Participant + Spouse	☐ Participant + Child	☐ Participant + Children	☐ Family
DELTA DENTAL PPO:	☐ Participant Only	☐ Participant + Spouse	☐ Participant + Child	☐ Participant + Children	☐ Family
VSP VISION:	☐ Participant Only	☐ Participant + Spouse	☐ Participant + Child	☐ Participant + Children	☐ Family

SECTION 2: SUBSCRIBER INFORMATION *(provide all requested information below regarding the primary COBRA subscriber)*

LAST NAME:	FIRST NAME:	DATE OF BIRTH:
SOCIAL SECURITY NUMBER:	FORMER EMPLOYEE ID:	MALE: ☐ FEMALE: ☐

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐REGISTERED DOMESTIC PARTNER (RDP) ☐ DIVORCED ☐ LEGALLY SEPARATED

STREET ADDRESS:	CITY:	STATE:	ZIP:

SECTION 3: DEPENDENT INFORMATION *(list all eligible family members to be enrolled – attach additional sheets if necessary)*

☐ Spouse ☐ RDP	LAST NAME:	FIRST NAME:	MI:
	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	MALE: ☐ FEMALE: ☐
	ADDRESS: ☐ *check if same as employee*	STREET ADDRESS:	
		CITY: / STATE:	ZIP:
Child	LAST NAME:	FIRST NAME:	MI:
	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	MALE: ☐ FEMALE: ☐
	OVERAGE DEPENDENT TYPE (IF APPLICABLE): ☐ DISABLED ☐ UNDER AGE 26		
	ADDRESS: ☐ *check if same as employee*	STREET ADDRESS:	
		CITY: / STATE:	ZIP:
Child	LAST NAME:	FIRST NAME:	MI:
	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	MALE: ☐ FEMALE: ☐
	OVERAGE DEPENDENT TYPE (IF APPLICABLE): ☐ DISABLED ☐ UNDER AGE 26		
	ADDRESS: ☐ *check if same as employee*	STREET ADDRESS:	
		CITY: / STATE:	ZIP:
Child	LAST NAME:	FIRST NAME:	MI:
	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	MALE: ☐ FEMALE: ☐
	OVERAGE DEPENDENT TYPE (IF APPLICABLE): ☐ DISABLED ☐ UNDER AGE 26		
	ADDRESS: ☐ *check if same as employee*	STREET ADDRESS:	
		CITY: / STATE:	ZIP:

SECTION 4: AUTHORIZATION

The information is complete and correct to the best of my knowledge. During the election period, I authorize BCC to make changes to my benefits as stated on this form. I understand that any changes postmarked after the election period will not be honored, and therefore my enrollment in the COBRA benefit program will not be processed.

SIGNATURE:	DATE:

FOR EMPLOYEE BENEFITS USE ONLY:

DATE ENTERED INTO SYSTEM:	ENTERED BY:

RETURN COMPLETED FORM TO: Benefit Coordinators Corporation (BCC)
Two Robinson Plaza, Suite 200, Pittsburgh, PA 15205 or customersupport@benxcel.com
QUESTIONS? Call BCC's Customer Service Call Center at 800-685-6100

BCC
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