PPi Benefit Solutions
ACSA Group Insurance Trust

COBRA CHANGE FORM
Fellowship Village

Employer No. 027660

Section 1 – Employee/Qualifying Beneficiary (QB) Information

Employee/QB Name		SSN				-			-			
Address	City	State	Zip	Phone Number								

Section 2 – Open Enrollment Plan Options

**NOTE: If you are an approved ARRA Assistance Eligible Individual (AEI), multiple the rate by 0.35 to determine the reduced rate. (Example: $503.15 x 0.35 = $176.10 ($176.10 would be the reduced rate that you would pay for COBRA.)

Plan	Teir	Monthly Rate	Please check below if your current coverage is no longer available OR you want to change plans/tier:
Aetna Gated POS - Basic Plan	Employee Only Employee + Spouse Employee + Child(ren) Family	$416.57 $841.48 $637.36 $1,141.41	I Elect Coverage Effective 2/1/10 Change Tier Status Effective 2/1/10 Drop Coverage Effective 2/1/10
Aetna Choice OA POS - Buy-Up Plan	Employee Only Employee + Spouse Employee + Child(ren) Family	$499.27 $1,008.53 $763.89 $1,367.99	I Elect Coverage Effective 2/1/10 Change Tier Status Effective 2/1/10 Drop Coverage Effective 2/1/10
Atena Freedom of Choice Dental	Employee Only Employee + 1Dependent Family	$35.07 $68.53 $108.68	I Elect Coverage Effective 2/1/10 Change Tier Status Effective 2/1/10 Drop Coverage Effective 2/1/10

Section 3 – Add/Drop Dependents (A=Add D=Drop)

Spouse

Full Name											SSN				-			-			
Date of Birth			/			/					Gender: M F										
Medical: A D																					
Dental: A D																					
Vision: A D																					

Child

Full Name											SSN				-			-			
Date of Birth			/			/					Gender: M F										
Medical: A D																					
Dental: A D																					
Vision: A D																					

Child

Full Name											SSN				-			-			
Date of Birth			/			/					Gender: M F										
Medical: A D																					
Dental: A D																					
Vision: A D																					

Please use a separate sheet of paper for additional dependents.

Section 4 – Employee/Qualifying Beneficiary Signature

By signing this form, I am acknowledging that I have read this form and I would like to elect or decline continuation coverage under the Group Health Plan(s) as indicated above. I understand that if I fail to pay any premium payment in a timely fashion, any continuation coverage elected will terminate. I also agree to notify PPI Benefit Solutions if I (or any member of my family) becomes covered under another group health plan or entitled to Medicare.

_____ ____ / ____ / _____
Employee/Former Employee Signature Date

_____ ____ / ____ / _____
Spouse/Former Spouse Signature Date

_____ ____ / ____ / _____
Dependent Signature (Age 18 and over) Date

PLEASE NOTE THE FOLLOWING:

If electing coverage, you are responsible for making timely payments (by the first of each month for premium due that month). ***If a Plan/Tier change is elected, revised coupons will be mailed upon receipt of your election change form.*** You will not receive a monthly statement reminding you that your premium is due as this is your responsibility as a COBRA participant. Please make checks payable to: ACSA and send to:

PPI Benefit Solutions
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Des Moines, IA 50305