

NOTICE TO COMPANY OF CHANGE IN PREMIUM RATES

(Please submit one form for each plan)

TO: Via Fax (724) 514-6648

Via E-Mail

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P.O. Box 8

Houston, PA 15342

FROM: _____ (“Client”) DATE: _____

_____ Contact name

_____ Contact Telephone

CHANGE IN PREMIUM RATES

As of _____, the applicable premium under

_____ (the “Plan”) shall be as follows:

Name of Insurance Company _____

Address _____

Customer Service Telephone _____

(Circle one:) Medical Dental Vision Prescription

Individual _____

Family _____

Individual + 1 _____

Individual + Spouse _____

Individual + Child _____

Individual + Children _____

Other (please specify) _____

Contract Year beginning date _____ to _____.

Can this be converted to an individual policy after Cobra term? Yes No

Age dependents become ineligible () Full time Student ()

Date coverage terminates - Last day of employment () End of the month ()