



COBRA Administration Opt In/Opt Out Form

Opt In: On behalf of the employer group below, I am authorized to accept the continuation of coverage (COBRA) services provided by CDPHP®.

Opt Out: On behalf of the employer group below, I am authorized to decline the continuation of coverage (COBRA) services provided by CDPHP®. For existing groups, this form must be received a minimum of 30 days prior to the requested effective date.

Employer Group Name:

Employer Group Number:

All Active Subgroups (including Retiree):

All Cobra Subgroups: _____

Effective Date: _____ **Group Renewal Date:** _____

CDPHP Administration - Opt In ☐ (CDPHP Billing Address) For existing groups, this request will go into effect the first of the month following 30 days after receipt of this form.	CDPHP Administration - Opt Out ☐ Re-enrollment outside of your renewal month will be reviewed by sales and underwriting for approval. Please provide CDPHP at least 30 days' notice prior to the requested effective date to re-enroll in continuation of coverage services.
Address Line 1: Lifetime Benefit Solutions	Address Line 1:
Address Line 2: 333 Butternut Drive Syracuse	Address Line 2:
Address Line 3:	Address Line 3:
City, State, Zip: Syracuse, NY, 13214	City, State, Zip:

Group Representative Signature:

Date Signed: _____