# COBRA Change Form

**Return completed form via email, fax or mail by November 19th, 2021**

Email: BMOHR.USBenefits@bmo.com Fax: (866) 932-6312

Mail: US Benefits, 395 N Executive Drive, 3rd Floor Brookfield, WI 53005

**You only need to complete this form if you are making changes for 2022**

| **Full Name (Print)** | **Social Security #** | **Birthdate** | **Telephone** |
|---|---|---|---|
| | | | |
| **Home Address** | **City** | **State** | **Zip Code** |
| | | | |

**ELECTIONS** - To make your changes to your elections, fill in the circle next to the plan and coverage level in the sections below.

| **Medical Plan** | **Medical Coverage Level** |
|---|---|
| ○ No coverage – Drop | ○ Employee only |
| ○ Consumer Choice Plan – BCBS *(ALL US)* **[BCHDHP]** | ○ Employee + Spouse/Domestic Partner[1] |
| | ○ Employee + Child(ren) |
| | ○ Employee + Family[1] |
| **Dental Plan** | **Dental Coverage Level** |
| ○ No coverage - Drop | ○ Employee only |
| ○ Delta Dental **[DLT]** | ○ Employee + Spouse/Domestic Partner[1] |
| | ○ Employee + Child(ren) |
| | ○ Employee + Family[1] |
| **Vision Plan** | **Vision Coverage Level** |
| ○ No coverage - Drop | ○ Employee only |
| ○ VSP **[VSP]** | ○ Employee + Spouse/Domestic Partner[1] |
| | ○ Employee + Child(ren) |
| | ○ Employee + Family[1] |

**DEPENDENTS** - To make your changes to your dependents, fill in the section below.

| Name | Relationship | Gender | Social Security # | Birthdate | Add or Remove | | |
|---|---|---|---|---|---|---|---|
| | | | | | Medical | Dental | Vision |
| | | | | | | | |
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**AUTHORIZATION –** Sign to authorize the changes listed on this form.

| **Signature** | **Date** |
|---|---|
| | |

[1] If you are enrolling a Domestic Partner or Domestic Partner's Children, attach a "Domestic Partner Certification" form (found on www.bmousbenefits.com under Forms and Documents > Additional Forms).