COBRA Change Form

Return completed form via email or fax by November 14th, 2025

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

You only need to complete this form if you are making changes for 2026

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

ELECTIONS - To make 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
○ HDHP – BCBS *(ALL US)* **[BCHDHP]**	○ Employee + Spouse/Domestic Partner
○ HDHP – KAISER *(N. CALIFORNIA)* **[KAIHDHPNCA]**	○ Employee + Child(ren)
○ HDHP – KAISER *(S. CALIFORNIA)* **[KAIHDHPSCA]**	○ Employee + Family
○ HDHP – KAISER *(COLORADO)* **[KAIHDHPCO]**	
○ HDHP – KAISER *(OREGON)* **[KAIHDHPOR]**	
○ PPO – BCBS *(ALL US)* **[BCPPO]**	
○ PPO – KAISER *(N. CALIFORNIA)* **[KAIPPONCA]**	
○ PPO – KAISER *(S. CALIFORNIA)* **[KAIPPOSCA]**	
○ PPO – KAISER *(COLORADO)* **[KAIPPOCO]**	
○ PPO – KAISER *(OREGON)* **[KAIPPOOR]**	
Dental Plan	**Dental Coverage Level**
○ No coverage - Drop	○ Employee only
○ Delta Dental High Plan **[DLTHIGH]**	○ Employee + Spouse/Domestic Partner
○ Delta Dental Low Plan **[DLTLOW]**	○ Employee + Child(ren)
	○ Employee + Family
Vision Plan	**Vision Coverage Level**
○ No coverage - Drop	○ Employee only
○ VSP High Plan **[VSPHIGH]**	○ Employee + Spouse/Domestic Partner
○ VSP Low Plan **[VSPLOW]**	○ Employee + Child(ren)
	○ Employee + Family

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

Name	Relationship	Gender	Social Security #	Birthdate	Add or Remove		
					Medical	Dental	Vision

AUTHORIZATION – Sign to authorize the changes listed on this form.

Signature	Date