

Employer, please complete the following information:

Date of issuing notice: \_\_\_\_\_

Date Employer Coverage Ends: \_\_\_\_\_

COBRA Effective Date: \_\_\_\_\_

**COBRA APPLICANT INFORMATION: Invoices will be sent to the indicated address**

Electing COBRA ?		Last Name	First Name	SS#	Birth Date	Gender
<input type="checkbox"/>	Applicant					
<input type="checkbox"/>	Spouse					
<input type="checkbox"/>	Child					
<input type="checkbox"/>	Child					
<input type="checkbox"/>	Child					
<input type="checkbox"/>	Child					
<input type="checkbox"/>	Child					

Address \_\_\_\_\_ Phone Number: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Reason establishing COBRA eligibility.

Date of qualifying event \_\_\_\_\_

18 Months Coverage:

- Reduction of work hours
- Termination of Employment
- Involuntary Termination of Employment

29 Months Coverage:

- Social Security Disabled

36 Months Coverage:

- Legal Separation or Divorce
  - Dependent Ceasing to be eligible
  - Death of Subscriber
- Please give primary members information  
 Name \_\_\_\_\_  
 SS# \_\_\_\_\_

You must complete this form and return it to your former employer within 60 days of the qualifying event date or the date of issuing notice, whichever is later. In order to continue your coverage, you will be required to make a monthly premium payment. If you do not return this form within the above time limit, it is assumed you have elected not to continue coverage. Each individual has an independent right to elect COBRA coverage.

**BREAKDOWN OF CHARGES:** Charges do not include administration fees of 2%.

Dental Member: \_\_\_\_\_ Plus One: \_\_\_\_\_ Plus Two or More: \_\_\_\_\_

Vision Member: \_\_\_\_\_ Plus Spouse: \_\_\_\_\_ Plus Child(ren) Only: \_\_\_\_\_ Family: \_\_\_\_\_

I do **NOT** wish to continue any coverage under the plan.

I HEREBY REQUEST ENROLLMENT IN THE HEALTH BENEFITS CONTINUATION PLAN FOR MYSELF AND ELIGIBLE QUALIFIED DEPENDENTS LISTED ON THIS FORM AND AGREE TO PAY THE PREMIUM AS REQUIRED. I UNDERSTAND THAT CONTINUATION COVERAGE WILL TERMINATE UNDER SEVERAL CIRCUMSTANCES, INCLUDING: THE DATE I OR A CONTINUED DEPENDENT BECOME COVERED UNDER ANOTHER GROUP PLAN, OR ON THE DATE ON WHICH THE GROUP PLAN ENDS. I ALSO UNDERSTAND THAT IF I WAS DISABLED WITHIN 60 DAYS OF THE COBRA QUALIFYING EVENT, I MAY BE ELIGIBLE FOR EXTENDED CONTINUATION COVERAGE.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
Signature of Applicant or Spouse or legal guardian, if electing on behalf of minor child.

**Company Information/ Certified by Employer**

**Federal COBRA members will be added to the Employer Invoice.**

Group Name: \_\_\_\_\_ Client ID: \_\_\_\_\_ - \_\_\_\_\_

Name of Individual certifying this notice: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you wish to continue your coverage, you must complete this form and return it to your former employer within 60 days of the date of issuing notice. In order to continue your coverage, you will be required to make a monthly premium payment. If you do not return this form within the above time limit, it is assumed you have elected not to continue coverage. Each individual has an independent right to elect COBRA coverage.

You have the right to choose continuation of coverage if you lose your group health coverage (dental and/or vision in this case) because of a reduction in work hours or termination of employment.

If you are the spouse or dependent of the covered person and have dependent coverage, you have the right to choose continuation of coverage for yourself if you lose coverage for any of the following reasons: (1) the death of your spouse; (2) the termination of your spouses employment or reduction of your spouse's hours of employment; (3) the employee's divorce or legal separation.

In the case of a covered dependent child of the covered employee, additionally he or she has the right to continuation of coverage if the group coverage is lost when the dependent child ceases to be a 'dependent child' under the covered person.

Under the law, the employee or family member has the responsibility to inform the plan administrator, of a divorce, legal separation, or a child losing dependent status within 60 days of the date of the employee's death, termination, and reduction in hours. When the plan administrator is notified that one of these events has occurred, we will notify you that you have the right to choose continuation of coverage. Under the law you have at least 60 days, from the date you would lose coverage, to inform the plan administrator that you want continuation of coverage. If you do not choose continuation of coverage in a timely manner your insurance coverage will end.

If you choose continuation coverage, the continued coverage under the plan is to be identical to similarly situation employees or family members as of the time coverage is being provided. The required continuation of coverage period is shown on the front of this notice with the indicated reason. The 18 month period may be extended for covered individuals to 36 months if other events such as death, divorce, legal separation or Medicare entitlement occur during that 18 month period.

The 18 months may be extended to 29 months if a qualified person is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11 month extension is available to all individuals who are qualified persons due to a termination or reduction in hours of employment. To benefit from this extension a qualified person must notify the plan administrator of that determination within 60 days and before the end of the original 18-month period. The covered individual must also notify the plan administrator within 30 days of any final determination that he/she is no longer disabled.

A child who is born or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to qualify for coverage, in accordance with plan terms, with proper notification to the plan administrator of the birth or adoption.

The law also provides that continuation of coverage may be cut short for any of the following five reasons: (1) employer no longer provides group dental coverage to any of its employees; (2) premium is not paid on time; (3) the qualified person becomes covered - after the date he/she elects COBRA coverage - under another group dental and/or vision plan that does not contain any exclusion or limitation with respect to any pre-existing condition; (4) the qualified person extends coverage for up to 29 months due to disability and a final determination finds the individual no longer disabled.

You do not have to show that you are insurable to choose continuation of coverage. However, continuation of coverage under COBRA is provided subject to your eligibility of coverage. The plan administrator reserves the right to terminate coverage retroactively if you are determined to be ineligible.

Under the law, you may have to pay all of part of the premium for your continuation of coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

To activate your continuation of coverage, complete the form and return it to the plan administrator within 60 days of your termination date. If you have changed marital status, or you (or your spouse), have changed addresses, please notify the plan administrator immediately.