ATTACHMENT C

COBRA ELECTION FORM

COBRA ENROLLEE INFORMATION	
Name	
Social Security Number	
Address	
City, State, Zip Code	
Daytime Phone Number (optional)	

If the enrollee is not the employee, then provide the employee's name and social security number, and your relationship to the employee.

Name of Employee:	Social Security Number:
Relationship to Employee:	

ELECTION TO ENROLL IN COBRA CONTINUATION COVERAGE	
Type of Coverage	Check Choice(s)
Medical	
Dental	
Vision	

Signature of Person Electing COBRA: _____ Date: _____

This election form must be completed and returned by _____ to the address shown below. If mailed, it must be postmarked by the date shown above. If you elect COBRA continuation coverage, then a separate enrollment form must be completed and sent to the plan for each benefit choice. The Personnel Office will assist in the completion of the required enrollment form(s).

Department Name and Address:	

Rev. 01/08