COBRA Medical/Dental Benefits Election Form

Subject to the terms stated in your Summary Plan Description, COBRA medical and/or dental benefits, may be available for you and/or your covered dependents. Please refer to the Summary Plan Description for terms and limitations. To apply for COBRA medical and/or dental benefits, please complete and return this form to your employer (or previous employer, in the event of termination of employment).

Employer name

Group number

Employee information

Employee name

Social Security number | Phone

Street address | Apt / Suite / PO box number

City | State | Zip code

Dependent information

Dependent name

Social Security number

Qualifying Event

Check the qualifying event that applies to you and indicate the date of the qualifying event in the blank

❑ Termination	Last date employed _____	❑ Marriage	Date of marriage _____
❑ Medicare	Date covered by Medicare _____	❑ Reduced Hours	Date hours reduced _____
❑ Legal Separation	Date legal separation filed _____	❑ Employee's Death	Date of death _____
❑ Dependent Child	Date dependent child ceased to be eligible dependent _____	❑ Divorce	Date divorce effective _____
		❑ Reservist	Date of active duty _____

Employer complete premium due for coverages. Date form is given to insured _____

Medical		Dental	
❑ Individual only	_____/Month	❑ Individual only	_____/Month
❑ Individual and spouse	_____/Month	❑ Individual and spouse	_____/Month
❑ Individual and child	_____/Month	❑ Individual and child	_____/Month
❑ Family	_____/Month	❑ Family	_____/Month

(Note: Rates are subject to any employer changes to plan.)

PREMIUMS MUST BE PAID TO THE EMPLOYER OR THE COBRA ADMINISTRATOR SELECTED BY YOUR EMPLOYER.

The initial premium is due within 45 days after the date COBRA is elected. Subsequent premiums are due monthly by the first of the month. Payment is considered timely if made within 31 days of the first of the month due date. Failure to submit a COBRA premium payment to the employer, or the employer's COBRA administrator, within the 31 day payment grace period will result in cancellation of coverage.

Signature of Person Electing or Waiving COBRA

❑ I elect COBRA

❑ I am waiving my right to COBRA

Employee signature _____ Date _____

Spouse signature _____ Date _____

Dependent signature _____ Date _____

(If Over Age 19)

SPOUSE AND DEPENDENT SIGNATURES ARE REQUIRED IF ANY DEPENDENT COVERAGE IS BEING WAIVED.

This form must be completed and returned within 60 days after or the later of: 1) the date that you would lose coverage, or 2) the date that you are sent notice of your right to elect COBRA. An election is considered to be made on the date that it is sent to your employer or plan sponsor. Failure to return this form within the specified time may result in the loss of COBRA privilege.

NOTE: If you are deemed Totally Disabled by the Social Security Administration prior to, or within 60 days of your COBRA election, you may be eligible to receive an additional 11 months of COBRA for you and your insured dependents. Please enclose your SSA Notice of Award with this application or within 60 days of receipt of your award notice.

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