☐ I ELECT COBRA CONTINUATION COVERAGE
☐ I DO NOT ELECT COBRA CONTINUATION COVERAGE

COBRA Enrollment Form

I. EMPLOYEE INFORMATION (Section I-III to be completed by Employer)

Employer Name	Division / Location	Social Security Number	Alternate ID Number

First Name	Last Name	MI	Sex ☐ Male ☐ Female	Date of Birth	Hire date

Home Address	City	ST	Zip Code	Home Phone Number ( )	Email Address

II. QUALIFYING EVENT TYPE
(Check the event that applies)

- ☐ Layoff
- ☐ Resignation
- ☐ Termination
- ☐ Reduction of Hours
- ☐ Divorce or Legal Separation
- ☐ Loss of Dependent Status
- ☐ Surviving Spouse/Dependent
- ☐ Social Security Disability (18 mo.)
  SSN of deceased EE ___ - - ____

III. PLAN INFORMATION
(Check the plans and effective date of the Qualifying Event)

MEDICAL
Plan Name: _____

Coverage:
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child
- ☐ Employee + Children
- ☐ Employee + Family

DENTAL
Plan Name: _____

Coverage:
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child
- ☐ Employee + Children
- ☐ Employee + Family

VISION
Plan Name: _____

Coverage:
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child
- ☐ Employee + Children
- ☐ Employee + Family

FSA
- ☐ Yes
- ☐ No

Monthly Amount: $_____

Severance Information
Amount: _____
End date: _____

QUALIFYING EVENT DATE	COBRA BEGIN DATE	GROUP NUMBER	ELIGIBILITY CODE	ELECTION NOTICE MAILED DATE	EMPLOYER SIGNATURE

IV. QUALIFIED BENEFICIARY / DEPENDENT INFORMATION & COVERAGE ELECTED

LAST NAME / FIRST NAME / MI	SSN	SEX	DATE OF BIRTH	MEDICAL	DENTAL	VISION	FSA
Employee		☐ M ☐ F		☐	☐	☐	☐
Spouse		☐ M ☐ F		☐	☐	☐	N/A
Child 1		☐ M ☐ F		☐	☐	☐	N/A
Child 2		☐ M ☐ F		☐	☐	☐	N/A
Child 3		☐ M ☐ F		☐	☐	☐	N/A

Applicant Signature: _____ **Date:** _____

Please retain a copy of this enrollment form for your records. Mail the original form to the following address:

BCBS

P.O. Box 226777

Dallas, TX. 75222-6777

Note: *The last day to elect coverage is within 60 days of the date coverage terminates (Qualifying Event Date) or the date coverage ends.*

You will lose your right to continue coverage if you do not complete and return this form within the 60-day time period allowed by law.