

COBRA

RIGHT TO CONTINUE GROUP HEALTH COVERAGE RETURN NOTICE

TO GUARANTEE YOUR CHOICE TO CONTINUE COVERAGE, RETURN THIS NOTICE ALONG WITH PREMIUM TO YOUR EMPLOYER.

Effective Date: _____ Health Yes () No ()

Effective Date: _____ Dental Yes () No ()

Effective Date: _____ Vision Yes () No ()

Name of Employee: _____

Employee Social Security Number: _____ Date of Birth: _____

Name of Employer: _____

Employer - verify first or second qualifying event:

Date last worked or date of qualifying event: _____

Reason for qualifying event: _____

Date of second qualifying event: _____

Do you have coverage under another Group Plan or under Medicare? Yes () No ()

If yes, Name of Company: _____

Group Policy Number: _____

I DO NOT WISH TO CONTINUE COVERAGE: ()

I WISH TO CONTINUE COVERAGE FOR: () Myself only
() Dependent(s) only, listed below
() Myself and my dependent(s), listed below

List ALL eligible individuals to be insured.

Name	Date of Birth	Social Security #	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(List additional dependents on back of sheet.)

I acknowledge that I must pay a monthly premium of \$_____ (obtain amount from employer). Further, I understand that the payment is due by the _____ of each month. The premium is based on the rate paid by other members of the group and may change in the future.

PLEASE NOTE THAT CONTINUATION OF THIS COVERAGE DOES NOT INCLUDE LIFE INSURANCE.

Employee Signature

Signature of Continuation Applicant

Address: _____
