Current COBRA Participants -Please print addition copies for additional participants

Name _____ ☐ Male ☐ Female

_____

_____ _____
e-mail Address

SSN _____ Date of Birth _____

Key Dates

Hire Date _____ Original Benefits Start Date _____

COBRA Event Date _____ COBRA Start Date _____

Premiums Paid Through (end of what month?) _____

☐ Involuntary Termination ☐ Voluntary Termination ☐ Employee's Death

☐ Divorce/Legal Separation ☐ Reduction of Hours Worked ☐ Loss of Dependent Status

Plan Information

Plan Name (HMO, PPO Etc)	Coverage (Family, EE+Spouse etc)	Monthly Premium

Does participant have Medicare/other coverage? ☐ Yes ☐ No

Dependents

Name	Date of Birth	SSN	Full Time Student
			☐
			☐
			☐
			☐