Office of Management and Enterprise Services
Employees Group Insurance Division
COBRA CONTINUATION COVERAGE ELECTION FORM

(PLEASE PRINT)

Name (COBRA Applicant) _____ SSN (COBRA Applicant) _____

Mailing Address _____
Street City State ZIP Code

Date of Birth _____ Marital Status _____ Phone #_____ Gender ☐ Male ☐ Female

Coverage elections (please check the box next to the coverage(s) you would like to continue):

☐ **HEALTH** ☐ **DENTAL** ☐ **VISION** ☐ **FLEXIBLE SPENDING ACCOUNT**

Primary Physican (HMO only) _____ Primary Dentist (Prepaid Only) _____

DEPENDENTS TO BE COVERED (Only if applicable)

NAME	SSN	RELATION	SEX	BIRTHDATE	HEALTH	DENTAL	VISION
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

1) Are you or any dependents to be covered on this plan covered by any other group insurance? ☐ Yes ☐ No
If yes, name of persons covered: _____
Name of Plan _____ Policy Number and Effective Date: _____

2) Are you or any dependents to be covered on this plan entitled to Medicare? ☐ Yes ☐ No
If yes, name of persons covered and effective date: _____

3) Were you terminated for gross misconduct? ☐ Yes ☐ No

I understand that my eligibility will be determined based on the information stated on this form. I must notify EGID if any changes occur which affect my eligibility. I understand that new dependents may be enrolled under limited circumstances. I understand all premiums from my active coverage must be paid in full to be eligible for COBRA continuation coverage.

I understand that all premiums due from the effective date of COBRA must be post-marked within 45 days following the date of signing this election form. Coverage will not be set up until premiums are received. To expedite coverage, you may submit premiums with this application.

Signature _____ **Date** _____

IMPORTANT INSTRUCTIONS: To elect COBRA continuation coverage, complete this election form and return it to your insurance/ benefit coordinator. Under federal law, you have at least 60 days after the date of this notice, _____, to decide whether you want to elect COBRA continuation coverage through EGID. If you do not submit a completed election form by the due date shown below, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date. Read and retain the important information about your rights.

This form must be completed and returned to our office by mail or fax. It must be postmarked or faxed no later than: _____. Forward the completed election form to your insurance/benefit coordinator at:

(FOR OFFICE USE ONLY)

Health Plan _____ Effective date _____
Dental Plan _____ Time limit _____
Vision Plan _____ Eligibility End _____
Total Premium _____ 1st Payment Due _____

Revised 03/29/2021