

# COBRA Enrollment Application

**Application must be COMPLETED in FULL, SIGNED and DATED for processing.**  
**PLEASE DO NOT ALTER THIS FORM AS THIS WILL DELAY PROCESSING.**

## EMPLOYER: Complete section below - then provide form to COBRA eligibles for completion

|  |   |
|--|---|
| <b>Qualifying/Triggering Event</b><br><input type="checkbox"/> Involuntary Termination <input type="checkbox"/> Death of Employee <input type="checkbox"/> Divorce/Legal Separation from Employee<br><input type="checkbox"/> Resignation <input type="checkbox"/> Medicare Entitlement<br><input type="checkbox"/> Reduction of Hours <input type="checkbox"/> Child No Longer Eligible | <b>Date of Qualifying/Triggering Event (MM/DD/YYYY)</b><br><input style="width: 100%; height: 20px;" type="text"/><br><b>Date of Election (MM/DD/YYYY)</b><br><input style="width: 100%; height: 20px;" type="text"/> |
| <b>Employee Last Name</b><br><input style="width: 100%; height: 20px;" type="text"/>   | <b>Employee Social Security #</b><br><input style="width: 100%; height: 20px;" type="text"/>  |
| <b>Employee First Name</b><br><input style="width: 100%; height: 20px;" type="text"/>  | <b>Group #</b><br><input style="width: 100%; height: 20px;" type="text"/>   |

† Date of Election is the date of postmark, fax, or other delivery means when the applicant returned this form.

## COBRA ENROLLEE: Complete all sections below

|   |   |
|---|---|
| <b>Applicant Last Name</b><br><input style="width: 100%; height: 20px;" type="text"/>   | <b>Applicant Social Security #</b><br><input style="width: 100%; height: 20px;" type="text"/>   |
| <b>Applicant First Name</b><br><input style="width: 100%; height: 20px;" type="text"/>  | <b>Relationship to Employee</b><br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)<br><input type="checkbox"/> Domestic Partner |
| <b>Your Address (required)</b><br><input style="width: 100%; height: 20px;" type="text"/>   | <b>Apt. #</b><br><input style="width: 50%; height: 20px;" type="text"/>   |
| <b>State</b> <b>ZIP Code</b> <b>County</b> <b>Daytime Phone #</b> <b>E-mail Address</b><br><input style="width: 10%; height: 20px;" type="text"/> <input style="width: 15%; height: 20px;" type="text"/> <input style="width: 20%; height: 20px;" type="text"/> <input style="width: 20%; height: 20px;" type="text"/> <input style="width: 25%; height: 20px;" type="text"/> | <b>City</b><br><input style="width: 100%; height: 20px;" type="text"/>  |
| <b>Mailing Address (if different from above)</b><br><input style="width: 100%; height: 20px;" type="text"/>   | <b>Apt. #</b> <b>City</b><br><input style="width: 50%; height: 20px;" type="text"/> <input style="width: 50%; height: 20px;" type="text"/>  |
| <b>State</b> <b>ZIP Code</b> <b>County</b><br><input style="width: 10%; height: 20px;" type="text"/> <input style="width: 15%; height: 20px;" type="text"/> <input style="width: 20%; height: 20px;" type="text"/>  | Please list <u>only</u> those individuals to be enrolled ↓  |

|                            | Employee  | Spouse/Domestic Partner   | Child 1   | Child 2   | Child 3   |
|----------------------------|---|---|---|---|---|
| Enrolling For?             | <input type="checkbox"/> Dental <input type="checkbox"/> Chiro<br><input type="checkbox"/> Vision | <input type="checkbox"/> Dental <input type="checkbox"/> Chiro<br><input type="checkbox"/> Vision | <input type="checkbox"/> Dental <input type="checkbox"/> Chiro<br><input type="checkbox"/> Vision | <input type="checkbox"/> Dental <input type="checkbox"/> Chiro<br><input type="checkbox"/> Vision | <input type="checkbox"/> Dental <input type="checkbox"/> Chiro<br><input type="checkbox"/> Vision |
| Last Name                  |   |   |   |   |   |
| First Name                 |   |   |   |   |   |
| Relationship to Employee   |   | <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner                         |   |   |   |
| Social Security #          |   |   |   |   |   |
| Gender                     | <input type="checkbox"/> Male <input type="checkbox"/> Female                                     | <input type="checkbox"/> Male <input type="checkbox"/> Female                                     | <input type="checkbox"/> Male <input type="checkbox"/> Female                                     | <input type="checkbox"/> Male <input type="checkbox"/> Female                                     | <input type="checkbox"/> Male <input type="checkbox"/> Female                                     |
| Date of Birth (MM/DD/YYYY) |   |   |   |   |   |

Please attach another sheet if you need more space to list dependents. COBRA coverage is only available to those persons who were enrolled on the policy the day before the Qualifying/Triggering Event occurred. Newly eligible dependents must be added within 30 days of becoming eligible (date of birth/adoption or date of marriage/domestic partnership). Dental, Chiro and Vision are only available to you if the employer group offers them. If you check off a column that the group does not offer, or that you were not enrolled on prior to your Qualifying/Triggering Event date, you will not be enrolled on that coverage under COBRA.

### Please read and sign below

I hereby apply for continuation of my coverage and those eligible members of my family listed above in the group health plan provided through ChoiceBuilder® for which I was covered on the date prior to the Qualifying/Triggering Event. I understand that I must immediately notify the employer from whom I obtained continuation of coverage upon: becoming covered under any other group health plan; becoming eligible for Medicare benefits; or if, as a former spouse of the subscriber, I remarry and become covered under the new spouse's group health plan. I understand that it is my responsibility to report to ChoiceBuilder any change in the eligibility of my dependents; that the benefits and services of this plan are coordinated with those provided by any group hospital or medical benefit or service plan; and that any controversy between any member and health plan (including its agents, staff physicians, employees and providers) involving a claim in tort, contract or otherwise, is subject to binding arbitration.

|                     |            |                   |
|---------------------|------------|-------------------|
| Applicant Signature | Print Name | Date (MM/DD/YYYY) |
|---------------------|------------|-------------------|

**PLEASE RETURN COMPLETED FORM TO YOUR PREVIOUS EMPLOYER**

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