



COBRA Participant Form

Please provide the following information for all individuals currently enrolled in COBRA (A), or individuals who are in their election period for COBRA (B) (eligible for COBRA). Please check one:

Current COBRA Participant

Eligible to elect COBRA (In COBRA Election Period)

Employer Name: _____

Employee Name
COBRA Participant: _____

Address: _____

SSN: _____ Date of Birth: _____

Date of Hire: _____ Original Benefit Start Date: _____

COBRA Start Date: _____ Date Coverage Lost (QE Date): _____

Qualifying Event Reason: _____ Current Paid Thru Date: _____

Name of Insurance Carrier (i.e. Kaiser, Blue Cross, Delta) and Coverage Type (HMO or PPO)

Medical: _____ Check one: HMO PPO

Check One: Employee Only Employee + Spouse Employee + Child Family

Dental: _____ Check one: HMO PPO

Check One: Employee Only Employee + Spouse Employee + Child Family

Vision Coverage: _____

Check One: Employee Only Employee + Spouse Employee + Child Family