PAYPRO ADMINISTRATORS

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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

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Dental: _____ Check one: ☐ HMO ☐ PPO

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

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Vision Coverage: _____

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