CAPITAL AREA HEALTH CONSORTIUM
Group #: 068965-015

ELECTION TO CONTINUE HEALTH BENEFITS – COBRA

Employee _____ **ANTHEM ID#**_____

Date of Qualifying Event: 6/30/2018 **Date Coverage Terminates:** 6/30/2018 **Date Notice Must Be Postmarked By**: 8/30/2018

NAME	**BIRTH DATE**	**SSN**	**RELATIONSHIP TO EMPLOYEE**	☑ **MEDICAL**	☑ **DENTAL**
1)				☐	☐
2)				☐	☐
3)				☐	☐
4)				☐	☐
5)				☐	☐
6)				☐	☐

Signature Date Address

Phone E-mail Address

Monthly Continuation Coverage Rate – ☑ Coverage for up to 18 Months (Terminating Employees)COBRA end date: 12/31/2019
☐ Coverage for up to 36 Months (Divorced/Legally Separated/Deceased) COBRA end date:

	ONE PERSON	**TWOPERSON**	**FAMILY**
CENTURY PREFERRED	**$771.20**	**$1568.63**	**$2093.62**
DENTAL	**44.67**	**116.16**	**144.65**

Make check payable to:
Capital Area Health Consortium
270 Farmington Ave., Suite 352
Farmington, CT 06032
Phone: 860-676-1110