

ELECTION TO CONTINUE HEALTH BENEFITS – COBRA

Employee _____

ANTHEM ID# _____

Date of Qualifying Event: 6/30/2017 Date Coverage Terminates: 6/30/2017 Date Notice Must Be Post Marked By: 8/30/2017

NAME	BIRTH DATE	SSN	RELATIONSHIP TO EMPLOYEE	MEDICAL <input checked="" type="checkbox"/>	DENTAL <input checked="" type="checkbox"/>
1) _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
2) _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
3) _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
4) _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
5) _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

I have been informed of my rights under COBRA.

Signature _____ Date _____ Address _____

Phone _____

Monthly Continuation Coverage Rate – Coverage for up to 18 Months (Terminating Employees) COBRA end date: **12/31/2018**
 Coverage for up to 36 Months (Divorced/Legally Separated/Deceased) COBRA end date: _____

	ONE PERSON	TWO PERSON	FAMILY
CENTURY PREFERRED	\$651.77	\$1303.48	\$1764.10
DENTAL	38.73	100.69	125.40

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