

ELECTION TO CONTINUE HEALTH BENEFITS – COBRA

Employee _____

ANTHEM ID# _____

Date of Qualifying Event: 06/30/2021 Date Coverage Terminates: 06/30/2021 Date Notice Must Be Postmarked By: Open due to COVID

NAME	BIRTH DATE	SSN	RELATIONSHIP TO EMPLOYEE	<input type="checkbox"/> MEDICAL	<input type="checkbox"/> DENTAL
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"/>
6) _____				<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date _____ Address _____

Phone _____ E-mail Address _____

Monthly Continuation Coverage Rate – Coverage for up to 18 Months (Terminating Employees) COBRA end date: 12-31-2022
 Coverage for up to 36 Months (Divorced/Legally Separated/Deceased) COBRA end date: _____

	ONE PERSON	TWO PERSON	FAMILY
CENTURY PREFERRED	\$660.82	\$1312.53	\$1736.68
DENTAL	<u>\$33.39</u>	<u>\$86.82</u>	<u>\$108.12</u>
	\$694.21	\$1,399.35	\$1,844.80

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