



Agency/College Name _____
 Date Form Provided To Employee _____

COBRA SBCCOE Benefit Plan Continuation of Medical/Dental/Vision Election Form

FOR HUMAN RESOURCES OFFICE ONLY

Name of Current Medical Plan and Option	Monthly COBRA Premium
Name of Current Dental Plan and Option	Monthly COBRA Premium
Name of Current Vision Plan	Monthly COBRA Premium
Health Care Spending Account	Monthly COBRA Premium
TOTAL COBRA MONTHLY PREMIUM	
Date Current Coverage Will End (without COBRA) COBRA Qualifying Date	

COBRA ELECTION (Check those which apply)

The SBCCOE group health care plan provides that employees and their qualified dependents whose medical/dental/vision coverage would otherwise terminate due to events called "qualified events" may elect to continue coverage for themselves and/or their qualified dependents currently covered.

Check the qualifying event that applies:	Number of Eligible Months of Coverage:
<input type="checkbox"/> Voluntary Termination of employment/retirement	18 Months
<input type="checkbox"/> Involuntary Termination of employment	18 Months
<input type="checkbox"/> Disability retirement/termination	29 Month (Proof Of Disability)
<input type="checkbox"/> Reduction of work hours	18 Months
<input type="checkbox"/> Death of an employee	36 Months
<input type="checkbox"/> Divorce, legal separation or termination of domestic partnership	36 Months
<input type="checkbox"/> Entitlement to Medicare for covered employee	36 Months
<input type="checkbox"/> Child losing eligibility	36 Months

- I wish to continue the group medical/dental/vision coverage
- I wish to continue my health care spending account (exceptions may apply) (Continuation is allowed only through the end of the current plan year)
- I decline/waive my right to elect COBRA coverage under the new plan

Sign below and return form to your Human Resources Office.

GENERAL INFORMATION (Instructions are on the reverse side of this form)

Employee Last Name	Employee First Name	M.I.	Social Security Number
Home Address	City	State	Zip Code
Home Telephone ()	Work Telephone ()		
Billing Address (If different than above)			

PARTICIPANTS TO BE COVERED UNDER COBRA

Note: To be eligible for COBRA, the individual(s) must have been enrolled under the employee's coverage prior to the qualifying date. List all persons (including yourself) and indicate the type of coverage you are selecting to be covered under COBRA. Select Yes or No under Medicare Eligible/Enrolled. If you or any other dependents are eligible for other medical/dental benefits, complete the "Other Medical/Dental Coverage Information" section below.*

Name: Last, First, M.I.	Social Security Number	Sex		Birth Date Mo/Day/Yr	Continue Medical		Continue Dental		Continue Vision		Continue Health Flex Spending Plan		Medicare Eligible/Enrolled	
		M	F		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Employee														
Spouse														
Domestic Partner														
Child														
Child														
Child														

***OTHER MEDICAL/DENTAL COVERAGE INFORMATION**

If you or any of your covered dependents are eligible for other _____ medical _____ dental benefits, complete the following:	
Policyholder Name:	Policy Number :
Other Carrier Name and Address:	
Organization through which coverage is offered and address:	

For individuals applying for COBRA Continuation of Coverage: It is understood and agreed that the foregoing answers are true and shall be the basis for the issuance of the medical/dental coverage applied for, and that the omission or misstatement of any material information in answer to the foregoing shall void this application for coverage. I further agree that my medical/dental carrier has the right to cancel my coverage in the event that I fail to cooperate in providing the company with these records or if I fail to pay the premiums within the required time period. A photographic copy of this authorization shall be as valid as the original.

COBRA ELECTION SIGNATURE (Must be signed and dated)

I hereby certify that I have read the conditions on the reverse side of this COBRA Continuation of Medical/Dental Coverage Election Form and that I (We) understand the terms of this coverage.	
<input type="checkbox"/> I wish to continue COBRA Coverage	<input type="checkbox"/> I decline/waive my COBRA coverage

Employee Signature _____ Date _____ * Spouse/DP Signature: (Check one) Current or Former _____ Date _____ * Dependent Signature _____ Date _____
 * If applying for or declining coverage on his/her own

WHITE copy: return to COBRA Coordinator, HealthSmart Benefit Solutions, 10303 E. Dry Creek Road, Suite 200, Englewood, CO 80112

PINK copy: Human Resources file copy.

YELLOW copy: Retain for your records.

COBRA CONTINUATION OF MEDICAL/DENTAL/VISION COVERAGE ELECTION FORM INSTRUCTIONS

Before completing this application for continuation of coverage, you must review the brochure describing your COBRA rights that is provided by your Human Resources Office. If you have not been provided a copy of this brochure, contact your Human Resources Office immediately for a copy. The brochure includes a description of your filing requirements and the reasons under the law that your coverage may be discontinued. Do not complete this form until you fully understand your rights and responsibilities under the law.

HOW TO COMPLETE THIS FORM

1. COBRA Election

You must either choose to continue coverage or decline/waive your right to continue. If you decline/waive your right to continue, please sign and return to your Human Resources Office.

2. General Information

- This information (employee name, address, social security number, agency name) should be the employee's information.
- COBRA Billing Address is for the applicant requesting COBRA coverage.
- If you are unaware of the date that your current coverage will cease (without COBRA), contact your Human Resources Office.
- Enter the exact date of the qualifying event (e.g., retirement, date of divorce, etc.).

3. Participants to be Covered Under COBRA

- List all (including yourself) of the individuals that are applying for continuation of coverage. To be eligible for coverage, the individual(s) must have been enrolled under the employee's coverage prior to the qualifying date. Also, a child who is born or placed for adoption with the employee during COBRA coverage is eligible for coverage. Be sure to include individual(s) Social Security Number and date of birth.
- For each individual applying for continuation of coverage, select yes or no in the appropriate boxes to continue medical, dental, vision and/or Health Care Spending Account and to indicate if you are Medicare Eligible/Enrolled in Medicare.

4. Other Insurance Coverage Information

- If you or any of your covered dependents are eligible for other group medical or dental benefits, you must complete this section.
- Enter the covered person's name, the policy number, name and address of the other insurance carrier, and the name and address of the company or organization through which such coverage is offered.

5. For Individuals applying for COBRA Continuation of Coverage

- Please read this paragraph carefully. Failure to cooperate in providing a medical or dental carrier with any necessary records or failure to pay the premiums within the required time period permits the carrier the right to cancel your coverage.

6. COBRA Election Signature(s)

- If applying for COBRA continuation, the employee must sign and date this form on the appropriate line.
- The spouse/former spouse, if applying for continuation of coverage on his/her own, must check the appropriate box (spouse or former spouse) then sign and date this form on the appropriate line.
- A dependent, if applying for continuation of coverage on his/her own, must sign and date this form on the appropriate line.
- A Spouse/Domestic Partner/Dependent declining continuation of coverage on his/her own must sign and date this form on the appropriate line.
- Retain the yellow copy for your records. Return the white copy to HealthSmart Benefit Solutions at the address at the bottom of the form.

7. For More Information

- If you are unsure of your rights and responsibilities under the law or need assistance in completing this form, contact your Human Resources Office.

8. Billing

- After you have been approved for continuation of COBRA coverage, you will receive monthly billings directly from HealthSmart Benefit Solutions, Inc.

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PINK copy: Human Resources file copy.

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