PRINT

COBRA CONTINUATION ELECTION FORM

Name:
Address:
City, State, Zip Code:
Daytime Phone #:
Date Mailed/Given to Enrollee:

List any and all dependents currently covered by your health, dental, and/or vision plan.

If COBRA enrollee is a dependent, provide name and social security number of the employee upon which COBRA eligibility is based:

NAME:	**SS#:**

✓CHECK ONE	TYPE OF QUALIFYING EVENT:	LENGTH OF COVERAGE
☐	Termination or Reduction in hours	18 months
☐	Retirement (Vision only)	18 months
☐	Divorce, termination of domestic partnership or legal separation	36 months
☐	Death of employee or Medicare entitled	36 months
☐	Child ceases to be a dependent	36 months

Date of Separation:

ELECTION TO ENROLL/DECLINE IN COBRA CONTINUATION COVERAGE

(You must check one option for EACH benefit you are currently enrolled in.)

Health	☐ I Choose to Enroll in COBRA Health Coverage	☐ I Decline COBRA Health Coverage
Dental	☐ I Choose to Enroll in COBRA Dental Coverage	☐ I Decline COBRA Dental Coverage
Vision	☐ I Choose to Enroll in COBRA Vision Coverage	☐ I Decline COBRA Vision Coverage

There is no COBRA Election for those enrolled in the Flex Cash Option.

SIGNATURE OF PERSON ELECTING/DECLINING ENROLLMENT:

NAME: _____ **DATE:** _____

Please return this election form within ***60 days*** of separation to the Personnel Dept.

If you elect COBRA coverage, additional enrollment documents must be completed for each benefit. The Personnel Office will assist you in the completion of the required enrollment forms.

CZU Felton Headquarters
Personnel Department
P.O. Drawer F-2
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