COBRA ENROLLMENT (Please Complete All Sections)

Group Name:	
Full Name of Employee:	
Address:	
Social Security Number:	Date of Birth:
Spouse Full Name (if covered):	
Spouse Social Security Number:	Date of Birth:
Qualifying Event Date:	**Date to Terminate Insurance:**

Please Check the Qualifying Event:

☐ Termination-Voluntary	☐ Death
☐ Termination-Involuntary	☐ Becoming an Ineligible Dependent
☐ Retirement	☐ Leave of Absence- Family/Medical
☐ Medicare Eligible	☐ Divorce/Separation
☐ Reduced Hours	

Has your company employed more than twenty employees on at least fifty percent of the business days in the preceding year? *This information will allow us to determine if your group falls under Federal COBRA or New York State Mini-COBRA.* ☐ YES ☐ NO

Coverage to be Offered:

Medical Carrier Name:_____

☐ HMO ☐ PPO
☐ POS ☐ Other
☐ EPO

Coverage For:

☐ Employee ☐ Employee & Children
☐ Employee & Spouse ☐ Employee & Family
☐ Employee & Child

Dental Carrier Name:_____

☐ Employee ☐ Employee & Children ☐ Employee & Spouse ☐ Employee & Family ☐ Employee & Child

Vision Carrier Name:_____

☐ Employee ☐ Employee & Children ☐ Employee & Spouse ☐ Employee & Family ☐ Employee & Child

Authorizing Signature: _____ **Date:**_____