



1—Group Employer Information. This section should be completed by the Employer Benefits Administrator. This application cannot be processed without this information and a signature. Please use blue or black ink, print one character per box.

Subscriber Status: Active Retired COBRA

Group # Subgroup # Class #

Employer Name

Association/Chamber Name (if applicable)

Group Administrator Signature / Date

Please indicate reason for COBRA:

Left Employment/Retirement Death of Spouse

Divorce/Legal Separation Dependent Reached Max Age

Loss of Student Status Other

Effective Date (MMDDYY) COBRA Effective Date (MMDDYY)

Hire/Rehire Date (MMDDYY) Retired Effective Date (MMDDYY)

2—Employer Plan Section Please use blue or black ink, print one character per box.

Location Name

Single Employee & Spouse Employee & Children Family

Option 1 Option 2 Option 3

3—Reason for Enrollment/Change - Employee, please indicate the reason for this enrollment or change.

New Hire COBRA Primary Care Physician Remove Dependent Loss of Coverage

Open Enrollment Address/Phone Number Last Name Retirement

Add Dependent - Please indicate reason for adding dependent: Newborn Marriage Loss of Coverage

Adoption

4—Employee Information

Please complete all sections. The subscriber signature is required in order to process the application.

Employee's Last Name Employee's First Name M.I.

Social Security Number Date of Birth (MMDDYY) Telephone Number (include area code) Gender: Female Male

Mailing Address Apt Suite Marital Status Single Married Divorced Legally Separated Widowed

City State Zip Code Marital Status Event Date (MMDDYY)

E-mail Address

Medicare Eligible - please indicate reason for Medicare eligibility: Age 65+ Disability End Stage Renal Disease

Medicare Number (if applicable) Part A Effective Date Part B Effective Date Part D Effective Date

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth (MMDDYY)

Gender: Female Male

Is your over-age dependent handicapped? Yes No

E-mail Address

Medicare Eligible - Please indicate reason for Medicare eligibility: Age 65+ Disability End Stage Renal Disease

Cell Phone Number

Permission to Text? Yes No

Primary Care Physician's Last Name

Primary Care Physician's First Name

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth (MMDDYY)

Gender: Female Male

Is your over-age dependent handicapped? Yes No

E-mail Address

Medicare Eligible - Please indicate reason for Medicare eligibility: Age 65+ Disability End Stage Renal Disease

Cell Phone Number

Permission to Text? Yes No

Primary Care Physician's Last Name

Primary Care Physician's First Name

6—Disclosure / Signature

Employee signature required.

I AUTHORIZE ANY LICENSED DOCTOR, HOSPITAL OR OTHER HEALTH CARE PROVIDER TO PROVIDE MY PLAN WITH ANY INFORMATION REQUESTED CONCERNING MEDICAL SERVICES I OR MEMBERS OF MY FAMILY HAVE RECEIVED, WHICH THE PLAN DETERMINES IS NECESSARY FOR THE OPERATION AND REGULATION OF THE PLAN. THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND IS VALID FOR UP TO 24 MONTHS.

Important: Please read and sign below:

*** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.**



Employee Signature _____ Date _____