



Application for Continuation of Benefits (COBRA)

Participant Information (Please print clearly)

Employee Name, Employee ID, Social Security No., Date of Birth, Dependent Name, Dependent Social Security No., Relation To Employee, Date of Birth, Mailing Address, City, State, Zip, Daytime Phone Number, E-Mail Address

Who is electing COBRA benefits? Employee [], Dependent []

2009 Plans and Monthly Rates (Prior to COBRA Event)

Table with columns for Plan Type (Individual, Spouse/Partner, Children, Family) and Monthly Rates for various insurance options (Aetna, BlueCross, CIGNA, VSP, HRA, FSA).

Dependents to be covered under your COBRA coverage

Table for dependents with columns: Name, Date of Birth, Social Security Number, and options for Medical, Dental, and Vision coverage.

Event Causing Change in Coverage (check one)

Checkboxes for: Reduction in Hours, Termination of Employment/Retirement, Divorce of Legal Separation, Employee Death, Dependent Reached Age 25.

Length of Coverage

Text describing coverage duration: Employee and/or Dependent coverage may be continued up to 18 months. Dependent coverage may be continued up to 36 months.

I am applying to continue my Health Care Plan coverage and understand I can only continue benefits for which I was enrolled the day before my COBRA event. I agree to pay the appropriate costs involved...

To enroll - complete, sign and return this form to Vanderbilt University COBRA Department (address below) within 60 days of the qualifying COBRA event. Initial payment is required within 45 days of election date to reinstate benefits under COBRA.

All payments must be in the form of a check or money order, made payable to Vanderbilt University and mailed to Vanderbilt University COBRA Department (address below). Include your COBRA ID or Social Security Number on all payments...

I understand by providing a Termination of Coverage Date on this form, I am providing a voluntary COBRA termination date and I am waiving my right to the full COBRA period. I understand this date will be the effective date my continued coverage will terminate...

I have read the "Notification of Rights to Continue Health Care Benefits" and understand that if any monthly payment is not received within 30 days from the due date, my COBRA coverage will be terminated.

Participant Signature: _____ Date: ___/___/___