COBRA Continuation Coverage Election Form

Participant Information

Full Name

Social Security Number

Mailing Address

City

State

ZIP Code

Phone Number

Email Address

Coverage Information

Qualifying Event

Date of Qualifying Event

Plan Names/Types

COBRA Coverage Begin Date

Election

☐ I elect to continue coverage under COBRA

Covered Individuals (If family coverage, list names, SSNs, and relationship)

Signature

Signature

Date