

COBRA Benefits Enrollment Form

Personal Information

Full Name

Social Security Number

Address

City

State

ZIP Code

Phone

Email

Coverage Election

Select Coverage(s)

☐

Medical

☐

Dental

☐

Vision

☐

Other

Plan Type

Dependent Information

Dependent Name

Date of Birth

SSN

Dependent Name

Date of Birth

SSN

Dependent Name

Date of Birth

SSN

Additional Information

Comments

Signature

Date