CAPITAL AREA HEALTH CONSORTIUM
Group #: 068965-026

ELECTION TO CONTINUE HEALTH BENEFITS – COBRA

Employee _____ **ANTHEM ID#**_____

Date of Qualifying Event: _____ **Date Coverage Terminates:** _____ **Date Notice Must Be Postmarked By**: _____

NAME	**BIRTH DATE**	**SSN**	**RELATIONSHIP TO EMPLOYEE**	**MEDICAL**	**DENTAL**
1)				☐	☐
2)				☐	☐
3)				☐	☐
4)				☐	☐
5)				☐	☐
6)				☐	☐

Signature Date Address

Phone_____ E-mail Address _____

Monthly Continuation Coverage Rate – ☑ Coverage for up to 18 Months (Terminating Employees)COBRA end date:_____
☐ Coverage for up to 36 Months (Divorced/Legally Separated/Deceased) COBRA end date:_____

	ONE PERSON	**TWO PERSON**	**FAMILY**
CENTURY PREFERRED	**$647.87**	**$1295.70**	**$1717.19**
DENTAL	**$36.62**	**$95.20**	**$118.55**

Make check payable to:
Capital Area Health Consortium
270 Farmington Ave., Suite 352
Farmington, CT 06032
Phone: 860-676-1110