

CAPITAL AREA HEALTH CONSORTIUM

Group #: 068965-MC01

068965-MC02

ELECTION TO CONTINUE HEALTH BENEFITS – COBRA

Employee _____

ANTHEM ID# _____

Date of Qualifying Event: _____ Date Coverage Terminates: _____

Date Notice Must Be Postmarked By: **60 days after coverage ends**

NAME	BIRTH DATE	SSN	RELATIONSHIP TO EMPLOYEE	MEDICAL	DENTAL	VISION
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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	\$713.71	\$1,416.16	\$1,873.43
DENTAL	\$33.39	\$86.82	\$108.12
VISION	<u>\$4.09</u>	<u>\$7.14</u>	<u>\$11.43</u>
	\$751.19	\$1,510.12	\$1,992.98

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