CAPITAL AREA HEALTH CONSORTIUM
Group #: 068965-MC01
068965-MC02
068965-VC03

ELECTION TO CONTINUE HEALTH BENEFITS – COBRA

Employee _____

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

NAME	BIRTH DATE	SSN	RELATIONSHIP TO EMPLOYEE	☐ MEDICAL	☐ DENTAL	☐ VISION
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	**$796.35**	**$1,575.44**	**$2,082.64**
DENTAL	**$32.07**	**$83.39**	**$103.84**
VISION	**$4.62**	**$8.96**	**$14.31**
	$833.04	**$1,667.79**	**$2,200.79**

These are the 2026-2027 rates, which adjust yearly on 7/1.

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

CAHC will not send notices or invoices of payments due. The amounts listed are the cost/per month.