CAPITAL AREA HEALTH CONSORTIUM
Group #: 068965-015

ELECTION TO CONTINUE HEALTH BENEFITS – COBRA

Employee ____ **ANTHEM ID#**____

Date of Qualifying Event: 6/30/2017 **Date Coverage Terminates:** 6/30/2017 **Date Notice Must Be Post Marked By**: 8/30/2017

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

I have been informed of my rights under COBRA.

Signature ______________________ Date ______________ Address ______________________________

Phone__________________________ ______________________________

Monthly Continuation Coverage Rate – ☐ Coverage for up to 18 Months (Terminating Employees) COBRA end date: **12/31/2018**
☐ Coverage for up to 36 Months (Divorced/Legally Separated/Deceased) COBRA end date:__________

	ONE PERSON	TWO PERSON	FAMILY
CENTURY PREFERRED	**$651.77**	**$1303.48**	**$1764.10**
DENTAL	**38.73**	**100.69**	**125.40**

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