



APPLICATION OF CONTINUATION OF VISION COVERAGE (COBRA)

VISION

Complete and return form to Surency by:

Email: eligibility@surency.com | Mail: P.O. Box 789773, Wichita, KS 67278-9773 | Fax: 316-462-3394

With the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans are required to offer employees and dependents losing eligibility the option to continue their coverage. If you wish to extend coverage, you must complete this form and return it to Surency. *You will then receive a coupon booklet from Surency or payment requests from your employer.*

APPLICANT INFORMATION

Name: _____ Social Security Number: _____

Date of Birth: _____ Male Female

Address: _____ City, State, ZIP: _____

Phone Number: _____ Email Address: _____

COVERAGE

Please list below all persons who are to be covered

Last Name (if different)	First Name	Middle Initial	Sex (M/F)	Date of Birth	Indicate if covered by other vision insurance
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Applicant: _____ Date: _____

Yes, I want to continue my vision coverage.

No, I do not want to continue my vision coverage.

TO BE COMPLETED BY EMPLOYER

Member ID # (on previous Surency coverage): _____ Date of Qualification: _____

Group Name: _____ Group Number: _____

Reasons for Loss of Eligibility *(Please check one)*

Note: Applications cannot be processed without this information.

Standard Length of Coverage - 18 months

End of employment

Reduction in hours of employment

Retirement

Standard Length of Coverage - 36 months

Divorce/Legal separation

Medicare enrollment of spouse/parent

Loss of dependent child status

Death of employee

Employer Signature: _____ Title: _____ Date: _____

Applicant eligible for _____ months of coverage. COBRA eligibility to terminate on _____