COBRA PARTICIPANT OR RETIREE ENROLLLMENT FORM

Surency COBRA

Employer Name: _____

PRIMARY QUALIFIED BENEFICIARY (PQB)

Last Name, First Name _____ Sex _____ Date of Birth _____

Mailing Address _____ City _____ State _____ ZIP _____

Social Security Number _____ Branch _____ Hire Date _____

Title _____ PQB ID _____

BENEFIT AND QUALIFYING EVENT INFORMATION

Qualifying Event Date _____ Loss of Coverage Date _____ Type of Qualifying Event _____

Current Medical Plan _____ Level of Coverage _____
Has had 18 months of prior coverage? ☐ Yes ☐ No

Current Dental Plan _____ Level of Coverage _____
Has had 18 months of prior coverage? ☐ Yes ☐ No

Current Vision Plan _____ Level of Coverage _____
Has had 18 months of prior coverage? ☐ Yes ☐ No

Current RX Standalone Plan _____ Level of Coverage _____
Has had 18 months of prior coverage? ☐ Yes ☐ No

Current FSA/HRA Plan _____ Level of Coverage _____
Has had 18 months of prior coverage? ☐ Yes ☐ No

Current EAP Plan _____ Level of Coverage _____
Has had 18 months of prior coverage? ☐ Yes ☐ No

Current Other Plans _____ Level of Coverage _____
Has had 18 months of prior coverage? ☐ Yes ☐ No

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COVERED DEPENDENT INFORMATION

Dependent 1

Last Name, First Name _____ Sex _____ Date of Birth _____ Social Security Number _____

Relationship to PQB _____ Plan Type Coverage _____

Mailing Address _____ City _____ State _____ ZIP _____

Dependent 2

Last Name, First Name _____ Sex _____ Date of Birth _____ Social Security Number _____

Relationship to PQB _____ Plan Type Coverage _____

Mailing Address _____ City _____ State _____ ZIP _____

Dependent 3

Last Name, First Name _____ Sex _____ Date of Birth _____ Social Security Number _____

Relationship to PQB _____ Plan Type Coverage _____

Mailing Address _____ City _____ State _____ ZIP _____

Dependent 4

Last Name, First Name _____ Sex _____ Date of Birth _____ Social Security Number _____

Relationship to PQB _____ Plan Type Coverage _____

Mailing Address _____ City _____ State _____ ZIP _____

FOR EXISTING COBRA PARTICIPANTS ONLY

Current Paid through Date _____ Credit Balance _____ Date of COBRA Election _____

SIGNATURE

I certify that all information provided in this form is accurate and complete to the best of my knowledge and belief. I hereby apply to extend my group insurance coverage under the terms of this program. I authorize Surency to bill me for monthly premium payments, and agree to make such payments in a timely fashion or my COBRA coverage will terminate. I agree to notify employer and/or Surency if I or any of my covered dependents become covered under another group health plan or become entitled to Medicare after I elect coverage under COBRA. I understand that any misrepresentations made herein could result in the termination of my COBRA coverage.

Signature: _____ Date: _____

Return completed form back to Surency at email: cobra@surency.com - fax: 316-272-4842
or mail: P.O. Box 789706, Wichita, KS 67278-9706

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