



# COBRA RETIREE/PARTICIPANT INFORMATION



## 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](mailto:cobra@surency.com) - fax: 316-272-4842  
or mail: P.O. Box 789706, Wichita, KS 67278-9706**

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