Application for Continuation of Group Vision Coverage (COBRA)

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 # _____ DOB _____

☐ 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 dental insurance
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ 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 and 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 _____ .

Return completed form back to Surency at email: eligibility@surency.com - fax: 316-462-3394
or mail: P.O. Box 789773, Wichita, KS 67278-9773
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