



ELECTION FORM FOR
COBRA CONTINUATION COVERAGE

Name of Employee: _____
(Last) (First) (Middle Initial)

MTU ID# _____ - _____ - _____ Date Mailed/Given: _____

COBRA INFORMATION

Name: _____ SS# _____ - _____ - _____

Date of Birth: _____ Phone: _____

Address: _____

City, State, Zip: _____

QUALIFYING EVENT

ELIGIBILITY

- | | |
|---|-----------|
| _____ Separation from Employment | 18 months |
| _____ Reduction in hours | 18 months |
| _____ Divorce, or legal separation | 36 months |
| _____ Death of employee | 36 months |
| _____ Child married | 36 months |
| _____ Child no longer a dependent | 36 months |
| _____ Has other insurance coverage | 36 months |
| _____ Social Security determines you are disabled | 29 months |

Date of the qualifying event: _____

Date when decision for COBRA coverage is due: _____

ELECTION TO ENROLL IN COBRA CONTINUATION COVERAGE

Enroll	Medical Coverage
	HuskyCare 1
	HuskyCare 2
	HuskyCare 3

Enroll	Dental/Vision Coverage
	Dental/Vision 1
	Dental/Vision 2

- Single Coverage
 Two Person Coverage
 Family 3 Coverage
 Family 4-6
 Family 7 +

COST OF ELECTED HEALTH INSURANCE PER MONTH: _____

Signature: _____

Date: _____