mesa·az | Employee Benefits

COBRA ENROLLMENT FORM

Employer Section Information		
□ New COBRA Enrollment	□ Change COBRA Coverage - Adding □ Change COBRA Coverage - Dropping	COBRA Effective Date: _____

COBRA Participant Information (Qualified Beneficiary)			
Last Name:	First Name: MI:		EE ID#:
Street:	City, State, Zip Code:		Date of Birth:
Home Phone #:	Work Phone #:	Gender: □ Male □ Female	SSN #:
Marital Status: □ Single □ Widowed □ Married □ Divorced	Name and EE ID # of Employee/Retiree you were previously covered under (if applicable):		

COBRA participants are entitled to the same health coverage they had when the loss of coverage event occurred. You can only enroll in the medical, dental, or vision plan in which you were enrolled prior to the loss of coverage date. New COBRA enrollees must select the same health plans they were previously enrolled in and may not change until a subsequent qualifying event, during an Open Enrollment period or as of a subsequent January 1st if the initial loss of coverage event is occurring in the months of October thru December of the current year.

Medical/Prescription Drug Coverage Election (**includes EAP)** (Choose One)	
Plan Election: □ Keep Current Plan □ Opt Out	Coverage: □ Member Only □ Dependent(s) Only □ Member & Family

Dental Coverage Election (Choose One)	
Plan Election: □ Keep Current Plan □ Opt Out	Coverage: □ Member Only □ Dependent(s) Only □ Member & Family

Vision Coverage Election (Choose One)	
Plan Election: □ Keep Current Plan □ Opt Out	Coverage: □ Member Only □ Dependent(s) Only □ Member & Family

Flexible Spending Account (Health) Election (Choose One)	
Plan Election: □ Keep Current Election on after-tax basis for up to remainder of current year	□ Opt Out

Dependent Information (List dependents continuing coverage below)

Relationship	Gender	Last	First	MI	DOB (MM/DD/YYYY)	SSN	Coverage
Spouse	□ M □ F						□ Medical □ Dental □ Vision
Child	□ M □ F						□ Medical □ Dental □ Vision
Child	□ M □ F						□ Medical □ Dental □ Vision
Child	□ M □ F						□ Medical □ Dental □ Vision

Agreement and Signature

I hereby apply for coverage for which I am eligible under the COBRA continuation provisions of the City of Mesa Health Plan. Except for initial payments (and any applicable benefit premium balances owed) when first electing COBRA continuation coverage, I know that premium payments are due by the 1st of each month of coverage, with a 30-day grace period thereafter. Unless I elect SurePay, payments must be made payable to the City of Mesa and delivered directly to the Employee Benefits Office located at 20 E Main, Suite 600, Mesa, AZ 85201 or mailed to: PO Box 1466, Mesa, AZ 85211-1466. If premiums are not paid by the last day of the grace period, I understand that my coverage will terminate the last day of the month for which premiums have been paid and I am no longer eligible for COBRA continuation benefits through the City of Mesa. Initial payments are due within 45 days of initial COBRA continuation election/enrollment. If payment is not made when due, COBRA Continuation Coverage will not take effect, even though an election may have occurred in a timely manner.

Signature:	Date:

For Office Use Only

Processed By: _____ Date: _____

Notes: _____

□ HRM □ Letter □ RD