COBRA Terms From 09/01/2008 to ___________

Today's Date: ____________ **Date of Hire:** ____________ **Date Coverage Began:** ____________

Employer Name: ______________________ **Location:** ____________

❒ Voluntary Termination of Employment	Last Day Worked:	____________	Date coverage ended:	____________
❒ Involuntary Termination of Employment	Last Day Worked:	____________	Date coverage ended:	____________
❒ Lay Off	Last Day Worked:	____________	Date coverage ended:	____________
❒ Reduction of Hours	Date Hours Reduced:	____________	Date coverage ended:	____________
❒ Divorce	Divorce Date:	____________	Date coverage ended:	____________
❒ Legal Separation	Date of Legal Separation	____________	Date coverage ended:	____________
❒ Loss of Dependent Status	Date of Loss:	____________	Date coverage ended:	____________
❒ Employee's Death	Date of Death:	____________	Date coverage ended:	____________
❒ Employee's Entitlement to Medicare	Date of Medicare:	____________	Date coverage ended:	____________

Name (please print)	**Social Security #**	**Date of Birth**	**Address Number**	**City**	**State**	**Zip**	**Phone**
Employee:							
Spouse:							
Child:							
Child:							
Child:							
Child:							
Child:							

Coverages:

❒ Medical	❒ Employee	❒ EE & Spouse	❒ EE & Child	❒ Family	**Plan #**	____________
❒ Dental	❒ Employee	❒ EE & Spouse	❒ EE & Child	❒ Family	**Plan #**	____________
❒ Vision	❒ Employee	❒ EE & Spouse	❒ EE & Child	❒ Family	**Plan #**	____________
❒ RX (if separate)	❒ Employee	❒ EE & Spouse	❒ EE & Child	❒ Family		____________

Print Name: ____________________ ***Signature:*** ______________________ ***Date:*** ____________

214 N. Main Street
P.O. Box 1053
Burlington, IA 52601

Administered By
Employee Benefit Systems
COBRA Department

Ph: 800-373-1327
Ph: 319-758-8467
Fax: 319-758-8567
lkulp@ebs-tpa.com