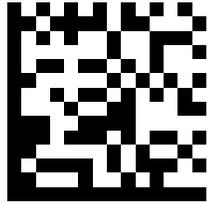


Case #: _____

COBRA Health Insurance Information



D14214001640102

- This form **MUST** be completed by your previous employer or your COBRA insurance company representative.
- Any blanks left on this form may delay the process.
- If you have general questions about this form or the medical programs, please call 1-866-435-7414.

A General Information

Policy Holder Name : _____ SS#: _____

Insurance Plan Name: _____ Policy #: _____

- Yes No 1. Is the individual eligible to enroll in COBRA coverage?
 If no, please explain: _____
 If yes, when is/was the policy holder eligible to enroll? (mm/dd/yy) _____
- Yes No 2. Is the COBRA coverage offered through Avenue H?
- Yes No 3. Is the individual or any family member enrolled in COBRA coverage?
 If yes, name(s) of person(s) enrolled: _____

- Yes No 4. Has the individual or any family member dropped/changed coverage in the last six months?
 If yes, name(s): _____
 If yes, when did coverage end/change? (mm/dd/yy) _____

B COBRA Plan

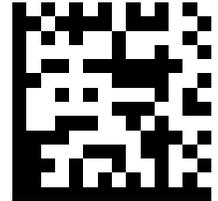
Questions below refer to the **COBRA** plan offered at your company or through Avenue H.

1. When will/did coverage begin? (mm/dd/yy) _____
2. Complete the charts below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$	\$
Employee + spouse	\$	
Employee + child	\$	
Family	\$	

Yearly Health Plan Deductible	
Individual amount	\$
Family amount	\$

C Policy Holder's Health Plan Choice



D14214001640202

Questions below refer to the plan that the policy holder has selected.

Questions 1-5 refer to the plan selected and only considers the "in-network" benefits.

- Yes No 1. Is the deductible \$2,500 or less per individual?
- Yes No 2. Is the lifetime maximum benefit \$1,000,000 or more?
- Yes No 3. Does the plan pay at least 70% of an inpatient stay (after the deductible)?
4. What benefits are covered under this plan? (Check all that apply.)
- Physician visits Hospital inpatient services Pharmacy/Rx
- Yes No 5. Does the plan cover abortion services?
- If yes, under what circumstances:
- Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
- Other, please describe: _____
- Yes No 6. Are the individual's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s): _____
- _____

D Signature

I certify that I am the applicant's former employer or that I am the COBRA insurance company representative. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

Please return completed form to:

Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Fax: 801-526-9500
Toll-free Fax: 877-313-4717