



COBRA Enrollment Application

See reverse side for mailing addresses.

Office Use Only

To Be Completed by the COBRA Applicant For additional dependents, check here and use additional application form.

Name	Last Name	First	Initial	Sex	Birthdate	Social Security Number	Primary Office Number	Dental Office Number
				M <input type="checkbox"/> F <input type="checkbox"/>	Mo. / Day / Year			(Complete if Applicable)
Applicant				<input type="checkbox"/>	/ /			
Spouse				<input type="checkbox"/>	/ /			
Oldest Child				<input type="checkbox"/>	/ /			
Child				<input type="checkbox"/>	/ /			
Child				<input type="checkbox"/>	/ /			

Home Address: _____ Apartment Number: _____ City: _____ State: _____ Zip Code: _____ Telephone Number: _____

Do any of the persons listed above live at another address? Yes No Yes, who and at what address? _____ Explain circumstances.

If last name of any dependent is different from yours, explain circumstances.

Spouse's Employer: _____ Do any of the persons listed above have any other group medical health insurance? Yes No

If yes, what insurance? Medicare A Medicare B Other _____

Name of Insurer: _____ Policy Number: _____

I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this application. Until I pay the full premium for the period since the latter of my qualifying event or my loss of coverage, I will be responsible for the costs of the health care for the persons listed above. I will be reimbursed for the health care delivered in accordance with my HMO coverage after I pay the full retroactive premium which is due within 45 days from the date of this election. I understand that all non-emergency services, in order to be covered by Aetna U.S. Healthcare™ must be performed by either my participating primary care physician or authorized by a prior referral from my participating primary care physician.

Aetna U.S. Healthcare Member Number: _____ Signature of COBRA Applicant: _____ Election Date: _____

To Be Completed by the Administrator

Name of Employer: _____ Submitted by (print): _____ Aetna U.S. Healthcare Customer Group Number: _____

Telephone Number: _____ COBRA Applicant's Current Member Number: _____ Date of Qualifying Event: _____ Date of Notice: _____ Date of Loss of Coverage (if different): _____

Is applicant a COBRA transfer from alternative group health plan? Yes (Must be during open enrollment period.) No

If transfer, please specify former health plan and member number: _____

A. Election of Payment Procedure (Check one box) Employer must choose same billing procedure for all COBRA enrollees

Home Billed: Please mail completed COBRA application to your designated regional office. (See reverse side for mailing addresses.)

Group Billed: For those employers on group billing for COBRA participants, retroactive premium charges will appear on the group bill. Please mail completed COBRA application to your designated regional office. (See reverse side for mailing addresses.)

B. Qualifying Event (Please check one) Applicant is eligible for COBRA coverage due to the qualifying event identified below

Employee's termination of employment - 18 months Loss of dependent status - 36 months Employer's reduction in hours - 18 months Divorce or legal separation - 36 months

Death of employee - 36 months Disability - Must be accompanied by a disability determination of the Social Security Administration - 18-29 months Medicare entitlement - 36 months

Employer Authorization (Signature) _____ Date: _____