Oklahoma State & Education Employees Group Insurance Board

A Division of the Office of State Finance

Certification of Previous Healthcare Coverage

PROOF OF LOSS

EMPLOYEE INFORMATION

SSN ________________________________

Name: ____
First Name MI Last Name

LAST DAY OF HEALTH COVERAGE

Month	Day	Year

Whose coverage is ending (check all that apply)

☐ Mine ☐ Spouse's ☐ Dependent Child(ren)'s ________________________________
Name(s)

REASON FOR LOSS OF COVERAGE

- ☐ Reaching age 65/Medicare eligible
- ☐ COBRA eligibility exhausted
- ☐ Employer coverage ending
- ☐ Other (please specify): ________________________________

I attest to continuous (check all that apply)

☐ Health Coverage ☐ Dental Coverage ☐ Vision Coverage

Signature ____

VERIFICATION OF PREVIOUS HEALTH CARE COVERAGES

Employer or COBRA administrator should complete if a HIPAA certificate, COBRA letter, or other documentation proving continuous coverage in prior plan is not available.

I attest that the above information is correct and that the person was continuously covered through our plan.

The last date of health, dental, and/or vision coverage is/was ________________________________
Month/Day/Year

Employer or COBRA Administrator ________________________________ *Phone (___)* ____________________

Signature ________________________________ *Title* ________________________ *Date* ____________