



OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD
COBRA CONTINUATION COVERAGE ELECTION FORM-Education or Local Government
(PLEASE PRINT)

NAME (COBRA Applicant) _____ SOCIAL SECURITY NUMBER (COBRA Applicant) _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SEX _____ TELEPHONE NUMBER _____

Coverage elections (please circle Yes or No):

HEALTH: Yes No DENTAL: Yes No

VISION: Yes No MEDICAL SPENDING (FSA) ACCOUNT: Yes No

(NOTE: You may not change plans at this time; however, if you are on an HMO and move out of their service area, your coverage will default to HealthChoice High. Members residing outside Oklahoma and Arkansas may choose HealthChoice USA.)

PRIMARY CARE DOCTOR (if you are on an HMO) _____

PRIMARY DENTIST (if you are on a DMO) _____

DEPENDENTS TO BE COVERED (Only if applicable)

NAME	SSN	RELATION	SEX	BIRTHDATE	HEALTH (Yes/No)	DENTAL (Yes/No)	VISION (Yes/No)

-Are you or any dependents to be covered on this plan covered by any other group insurance? Yes No

If yes, name of persons covered: _____

Name of Plan _____ Policy Number & Effective Date _____

-Are you or any dependents to be covered on this plan entitled to Medicare? Yes No

If yes, name of persons covered and effective date: _____

-Were you terminated for gross misconduct? Yes No

I understand that my eligibility will be determined upon the information stated on this form. I must notify the OSEEGIB if any changes occur which affect my eligibility. I understand that new dependents may be enrolled under limited circumstances. I understand all premiums from the active account must be paid in full to be eligible for COBRA continuation coverage.

I understand that all premiums due from the effective date of COBRA must be post-marked within 45 days following the date of signing this election form. Coverage will not be set up until premiums are received. To expedite coverage, you may submit premiums with this application.

Signature _____

Date _____

IMPORTANT INSTRUCTIONS: To elect COBRA continuation coverage, complete this election form and return it to your Insurance Coordinator. Under federal law, you have at least 60 days after the date of this notice, _____, to decide whether you want to elect COBRA continuation coverage under the Plan. If you do not submit a completed election form by the due date shown below, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date. Read and retain the important information about your rights included in the pages after the election form.

This form must be completed and returned to your Insurance Coordinator either by mail or fax. It must be postmarked or faxed no later than: _____

Forward completed election form to your Insurance Coordinator at:

(FOR OFFICE USE ONLY)

Health Plan _____	Effective date _____
Dental Plan _____	Time limit _____
Vision Plan _____	Eligibility Ends _____
Total Premium _____	1 st Payment Due _____