



**Office of Management and Enterprise Services  
 Employees Group Insurance Department  
 Certification of Previous Coverage  
 PROOF OF LOSS**

**EMPLOYEE INFORMATION**

SSN \_\_\_\_\_

Name \_\_\_\_\_  
First Name MI Last Name

**LAST DAY OF HEALTH COVERAGE**

The last date of health coverage is/was \_\_\_\_\_  
 Month/Day/Year

Coverage is ending for (check all that apply)

Self  Spouse  Dependent Child(ren) \_\_\_\_\_  
 Name(s)

**REASON FOR LOSS OF COVERAGE**

- Reached age 65/Medicare eligible
- COBRA eligibility exhausted
- Employer coverage ended
- Other (please specify) \_\_\_\_\_

I attest to continuous (check all that apply)

Health Coverage  Dental Coverage  Vision Coverage

Signature \_\_\_\_\_

**CERTIFICATION OF PREVIOUS COVERAGE**

Employer or COBRA administrator should complete this section 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 all persons listed were continuously covered through our plan.

The last date of health, dental and/or vision coverage \_\_\_\_\_  
 Month/Day/Year

Employer or COBRA administrator \_\_\_\_\_ Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_