COBRA Application

AvMed

Information for Covered Employee

Employee Name (First, M.I., Last) | Member ID#

Employee Address | City | State | Zip

Home Telephone | Employer Name | Employer Telephone

Provide the following information for those persons requesting continuation of coverage

*(Members must be **currently covered** in plan)*

First Name/ Last Name | Relationship (*Self)* | Date of Birth *(mm/dd/yy)*

Social Security | Primary Care Physician Name | Provider Number

First Name/ Last Name | Relationship (*Spouse)* | Date of Birth *(mm/dd/yy)*

Social Security | Primary Care Physician Name | Provider Number

First Name/ Last Name | Relationship (*Child)* | Date of Birth *(mm/dd/yy)*

Social Security | Primary Care Physician Name | Provider Number

First Name/ Last Name | Relationship (*Child)* | Date of Birth *(mm/dd/yy)*

Social Security | Primary Care Physician Name | Provider Number

First Name/ Last Name | Relationship (*Child)* | Date of Birth *(mm/dd/yy)*

Social Security | Primary Care Physician Name | Provider Number

Dependent Address (if different from subscriber): _____ City: _____ State: _____ Zip: _____

I hereby apply for COBRA Continuation of Coverage (I understand that, under Florida law, any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.) **Applicant Signature:** _____ **Date:** _____

Employer Use Only	**Date of Qualifying Event**
1. Termination of Employment (18 mos.)	
2. Reduction of Employee Work Time (18 mos.)	
3. Medicare Entitlement (36 mos.)* **	
4. Divorce or Legal Separation (36 mos.)* **	
5. Dependent Child Ceasing to be a Dependent (36 mos.)* **	
6. Death of the Employee (36 mos.)* ** ***Continued Coverage available only for dependents	

The deadline for providing Notice of Disability is 60 days after the latest of: 1) the date of the Social Security Administration's disability determination; 2) the date of the covered employee's termination of employment or reduction in hours; and 3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination or reduction. Your Notice of Disability must also be provided within 18 months after the covered employee's termination of employment or reduction in hours.

Effective date of COBRA: _____

Employer/Administrator Signature: _____ **Date:** _____