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East Lansing, MI 48826-2560
Questions? Call 888.888.4167
Fax 517.203.2914
www.messa.org

COBRA Application

Please PRINT clearly or TYPE

MEMBER INFORMATION

Form with fields for SOCIAL SECURITY NUMBER, DATE OF BIRTH, GENDER (MALE/FEMALE), FIRST NAME, LAST NAME, MAILING ADDRESS, APT #, CITY, STATE, ZIP CODE, HOME PHONE, and E-MAIL.

DEPENDENT INFORMATION

Please refer to your MESSA Plan Coverage Booklet at www.messa.org for complete eligibility guidelines. If necessary, include additional dependent information on a separate sheet of paper and attach to this application.

Table with 4 rows for dependent information, including columns for SPOUSE, SOCIAL SECURITY NUMBER, DATE OF BIRTH, GENDER, and Relationship to Member.

COVERAGE INFORMATION

IMPORTANT: If this application is for the MESSA Subsidy for Continuation of Coverage - prepayment is NOT REQUIRED for medical coverage but IS REQUIRED for dental or vision coverage.

A COBRA CONTINUATION You may only continue the coverage in which you are currently enrolled.

Form for selecting coverage types: MEDICAL COVERAGE, DENTAL COVERAGE, and VISION COVERAGE, with options for MEMBER, MEMBER & SPOUSE, MEMBER & CHILD, and FULL FAMILY, and associated cost fields.

FOR EMPLOYER'S USE ONLY

Form for employer use including fields for SSN, Qualifying Event, COBRA effective date, Comments, and checkboxes for prepayment requirements.

TOTAL CONTRIBUTION

Form for EMPLOYER'S INITIALS & DATE and EMPLOYER'S STAMP, and SIGNATURE OF APPLICANT and DATE (MM-DD-YYYY).