

COBRA Application

Please PRINT clearly or TYPE

MEMBER INFORMATION

SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM-DD-YYYY)	MALE	FEMALE	FIRST NAME	LAST NAME
MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE	HOME PHONE
					()
					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.

SPOUSE	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM-DD-YYYY)	GENDER
			MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
Dependent	Relationship to Member		
			MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
Dependent	Relationship to Member		
			MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
Dependent	Relationship to Member		
			MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
Dependent	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.

<input type="checkbox"/> MEDICAL COVERAGE:	<input type="checkbox"/> MEMBER <input type="checkbox"/> MEMBER & SPOUSE <input type="checkbox"/> MEMBER & CHILD <input type="checkbox"/> FULL FAMILY	\$ _____
<input type="checkbox"/> DENTAL COVERAGE:	<input type="checkbox"/> MEMBER <input type="checkbox"/> MEMBER & SPOUSE <input type="checkbox"/> MEMBER & CHILD <input type="checkbox"/> FULL FAMILY	\$ _____
<input type="checkbox"/> VISION COVERAGE:	<input type="checkbox"/> MEMBER <input type="checkbox"/> MEMBER & SPOUSE <input type="checkbox"/> MEMBER & CHILD <input type="checkbox"/> FULL FAMILY	\$ _____
		TOTAL CONTRIBUTION \$ _____

FOR EMPLOYER'S USE ONLY

If COBRA coverage is for dependent or spouse, list enrollee SSN: _____

Qualifying Event: _____

COBRA effective date: _____

Comments: _____

No prepayment required - school district pays online. Prepayment submitted with application.

Prepayment will be submitted separately.

EMPLOYER'S INITIALS & DATE and EMPLOYER'S STAMP (Name & Group Number)

SIGNATURE OF APPLICANT	DATE (MM-DD-YYYY)
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