ELECTION FORM FOR COBRA CONTINUATION COVERAGE

CURRENT SUBSCRIBER (Employee/Retiree)
Name: _____ SSN: _____

COBRA ENROLLEE INFORMATION SSN: _____

Name: _____ Married: ___ yes
Address: _____ ___ no
_____ Sex: _____ male
Phone: _____ _____ female

DEPENDENT INFORMATION (List all persons to be enrolled)

Name(s):	Birth Date	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

QUALIFYING EVENT/COVERAGE LENGTH

_____ Employment Separation (18 months)
_____ Reduction in Hours (18 months)
_____ Divorce/Legal Separation (36 months)
_____ Death of an Employee (36 months)
_____ Child Marries (36 months)
_____ Child attained age 23 (36 months)

ENROLLMENT ELECTION

	Enroll	Decline
Health	_____	_____
Dental	_____	_____
Vision	_____	_____

Qualifying Event Date: _____

Separate enrollment documents will be mailed to you if you elect coverage. Please return this election form within 60 days to:

CSU Bakersfield Foundation
Human Resource – ADM 104
9001 Stockdale Hwy.
Bakersfield, CA 93311-1099

_____ _____
Signature Date