CAPITAL AREA HEALTH CONSORTIUM
Group #: 068965-MC02
068965-DC02
068965-VC04

ELECTION TO CONTINUE HEALTH BENEFITS – COBRA

Employee _____ **ANTHEM ID#**_____

Date of Qualifying Event: _____ Date Coverage Terminates: _____ Date Notice Must Be Postmarked By: **60 days after coverage ends**

NAME	**BIRTH DATE**	**SSN**	**RELATIONSHIP TO EMPLOYEE**	**MEDICAL**	**DENTAL**	**VISION**
1)				☐	☐	☐
2)				☐	☐	☐
3)				☐	☐	☐
4)				☐	☐	☐
5)				☐	☐	☐
6)				☐	☐	☐

Signature Date Address

Phone_____ E-mail Address _____

Monthly Continuation Coverage Rate – ☑ Coverage for up to 18 Months (Terminating Employees)COBRA end date:_____
☐ Coverage for up to 36 Months (Divorced/Legally Separated/Deceased) COBRA end date:_____

	ONE PERSON	**TWO PERSON**	**FAMILY**
CENTURY PREFERRED	**$713.71**	**$1,416.16**	**$1,873.43**
DENTAL	**$33.39**	**$86.82**	**$108.12**
VISION	**$4.09**	**$7.14**	**$11.43**
	$751.19	**$1,510.12**	**$1,992.98**

Make check payable to:
Capital Area Health Consortium
270 Farmington Ave., Suite 352
Farmington, CT 06032
Phone: 860-676-1110