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

ELECTION TO CONTINUE HEALTH BENEFITS – COBRA

Employee _____ **ANTHEM ID#**_____

Date of Qualifying Event: 6/30/23 **Date Coverage Terminates:** 6/30/23 **Date Notice Must Be Postmarked By**: 8/29/23

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: 12/31/24
☐ Coverage for up to 36 Months (Divorced/Legally Separated/Deceased) COBRA end date: _____

	ONE PERSON	**TWO PERSON**	**FAMILY**
CENTURY PREFERRED	**$709.56**	**$1,403.73**	**$1,855.64**
DENTAL	**$32.07**	**$83.39**	**$103.84**
VISION	**$4.62**	**$8.96**	**$14.31**
	$746.25	**$1,496.08**	**$1,973.79**

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

CAHC will not send notices or invoices of payments due. The amounts listed are the cost/per month.