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

ELECTION FORM – COBRA CONTINUATION

Employee ____

Date of Qualifying Event: _____ **Date Coverage Terminates:** _____ **Date Notice Must Be Postmarked By**:

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
MEDICAL	**$723.75**	**$1,431.80**	**$1,892.75**
DENTAL	**$32.07**	**$83.39**	**$103.84**
VISION	**$4.62**	**$8.96**	**$14.31**
MONTHLY COST	**$760.44**	**$1,524.15**	**$2,010.90**

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.