OKLAHOMA
Employees Group Insurance Division

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COBRA CONTINUATION COVERAGE ELECTION FORM

To elect COBRA continuation coverage, complete this election form and return it to your insurance coordinator. Under federal law, you have at least 60 days after the date of this notice (_____) to decide whether you want to elect COBRA continuation coverage through EGID. If you do not mail or fax a completed election form by the due date shown below, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind if you furnish a completed election form before the due date. Read and retain the important information about your rights. **Postmark/fax due date:**

Applicant information

Name (First MI Last)		SSN
Date of birth (DOB)	☐ Male ☐ Female	☐ Married ☐ Single
Mailing address (☐ New)	City State ZIP code	
Phone	Alt phone	Email

Coverage elections – Select the coverages you want to continue.

☐ Health ☐ Dental ☐ Vision ☐ Flexible spending account (FSA)

Primary care physician (HMO): | Primary care dentist (Prepaid):

Dependents to be covered (if applicable)

Name	SSN	Relation	Sex	DOB	Coverage elections
					☐ Health ☐ Dental ☐ Vision
					☐ Health ☐ Dental ☐ Vision
					☐ Health ☐ Dental ☐ Vision

Questions

1. Are you or any dependents to be covered on this plan covered by any other group insurance?
☐ Yes ☐ No

If yes, name of plan: Effective date:

Person(s) covered:

2. Are you or any dependents to be covered on this plan entitled to Medicare?
☐ Yes ☐ No

If yes, person(s) covered and effective date:

3. Were you terminated for gross misconduct?
☐ Yes ☐ No

Signature

I understand that my eligibility will be determined based on the information stated on this form. I must notify EGID if any changes occur which affect my eligibility. I understand that new dependents may be enrolled under limited circumstances. I understand all premiums from my active coverage must be paid in full to be eligible for COBRA continuation coverage.

I understand that all premiums due from the effective date of COBRA must be postmarked within 45 days following the date of signing this election form. Coverage will not be set up until premiums are received. To expedite coverage, you may submit premiums with this application.

Signature: **Date:**

Mail or fax to EGID, Attn: Member Accounts

Mail: EGID, P.O. Box 11137, Oklahoma City, OK 73136-9998 | **Fax:** 405-717-8939

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Health plan:	Dental plan:	Vision plan:	Total premium:
Effective date:	Time limit:	Eligibility end:	1st payment due: