OKLAHOMA
Office of Management
& Enterprise Services

Employees Group Insurance Division

Certification of Previous Coverage
Proof of Loss

Employee Information

SSN _____

Name _____
First name MI Last name

Last Day of Prior Coverage

The last date of prior coverage is/was _____
Month/Day/Year

Coverage is ending for (check all that apply)

☐ Self ☐ Spouse ☐ Dependent Child(ren) **Names**: _____

_____

Reason for Loss of Coverage

- ☐ Reached age 65/Medicare eligible
- ☐ COBRA eligibility exhausted
- ☐ Employer coverage ended
- ☐ Other (please specify) _____

I attest to continuous (check all that apply)

☐ Health Coverage ☐ Dental Coverage ☐ Vision Coverage

Employee Signature _____

Certification of Previous Coverage

Employer or COBRA administrator should complete this section if a HIPAA certificate, COBRA letter or other documentation proving continuous coverage in prior plan is not available.

I attest that the above information is correct and that all persons listed were continuously covered through our plan.

The last date of (health / dental / vision) coverage _____
circle all that apply Month/Day/Year

Employer or COBRA administrator _____ Phone _____

Signature _____ Title _____ Date _____