COBRA
Election Form

_____ S.S.#_____
Name (please print)

COBRA Eligibility Dates_____

Please check one of the following boxes:

☐ I **accept** COBRA coverage.

Please choose the coverage desired:

☐ **Individual**:

☐	Medical	$ 849.01 per month
☐	Excess Medical	$ 3.57 per month
☐	Dental	$ 47.22 per month

☐ **Family**:

☐	Medical	$ 1926.21 per month
☐	Excess Medical	$ 7.65 per month
☐	Dental	$ 79.19 per month

☐ I **decline** COBRA coverage:

Signature_____Date_____

FOR OFFICE USE ONLY

Processed into ☐FM ☐NYBEAS_____Date_____

Sent to Business Office_____Date_____

Cc: LD

Updated 07/27/16