



Benefit Management Services
P.O. Box 98044
Baton Rouge, LA 70898-9044

**COBRA
ENROLLMENT CARD**

TYPE OF COVERAGE ADDED: MEDICAL DENTAL ALL

EMPLOYEE INFORMATION

LAST NAME (Please Print)		FIRST NAME		M.I.	SOCIAL SECURITY NUMBER	
STREET ADDRESS			CITY		STATE, ZIP	
GROUP NUMBER	ORIGINAL EFFECTIVE DATE OF MEDICAL COVERAGE			HIRE DATE		TERM DATE
EFFECTIVE DATE OF COBRA		TERM DATE OF COBRA		NUMBER OF MONTHS TO BE COVERED UNDER COBRA		

REASON(S) FOR GROUP COVERAGE ENDING

Death of the covered employee
 Termination of employment of the covered employee (other than by reason of the employee's gross misconduct) or reduction in hours
 The divorce or legal separation of the covered employee from the employee's spouse The covered employee's commencement of medicare coverage
 The end of dependent child coverage under the terms of the plan Employee leaving employment due to disability

PLEASE ADD THE FOLLOWING DEPENDENTS TO MY COBRA COVERAGE

GIVE FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH			CHECK RELATIONSHIP. IF ADDING SPOUSE, GIVE DATE OF MARRIAGE. IF ADDING STEPCHILD, GIVE DATE DEPENDENCY BEGAN, PERCENT SUPPORT, AND INDICATE IF CLAIMED ON INCOME TAX.			
		MO.	DAY	YR.	<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE	DATE OF MARRIAGE	IS DEPENDENT CLAIMED ON INCOME TAX?	
SPOUSE								
OLDEST CHILD					<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> OTHER (Specify)	DATE DEPENDENCY BEGAN	% SUPPORT	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER			<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> OTHER (Specify)	DATE DEPENDENCY BEGAN	% SUPPORT	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER			<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> OTHER (Specify)	DATE DEPENDENCY BEGAN	% SUPPORT	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER			<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> OTHER (Specify)	DATE DEPENDENCY BEGAN	% SUPPORT	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER			<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> OTHER (Specify)	DATE DEPENDENCY BEGAN	% SUPPORT	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER			<input type="checkbox"/> YES <input type="checkbox"/> NO

FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form or application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICANT'S SIGNATURE **X** _____ DATE _____

EMPLOYEE'S SIGNATURE X	DATE
AUTHORIZED GROUP REPRESENTATIVE X	PROPOSED EFFECTIVE DATE