

State of Ohio  
**COBRA ELIGIBILITY  
NOTIFICATION**

This is not an Enrollment Form.  
Do not send payment with this form.  
Please type or print.

		<b>Bargaining Unit Number</b>
Name of Eligible Beneficiary		Date of Birth
Street Address		
City	County	State      Zip
Social Security Number	Home Phone Number (    )	Is the Eligible Beneficiary: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Qualifying Event	Last Date of State Insurance	

Eligible Beneficiary: Last Name

**Type of Qualifying Event**

Event 'A' Qualifies you for 18 months of continued coverage.

**A** Employment ended due to (mark below):

<input type="checkbox"/> Voluntary Termination	<input type="checkbox"/> Retirement of Employee	<input type="checkbox"/> Involuntary Termination	<input type="checkbox"/> Loss of Health Care due to Change in Status
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Events B, C and D qualify dependent family members for 36 months of continued coverage.

**B\*** Death of the employee.

**C\*** Divorce or legal separation from employee.

**D\*** Dependent child's loss of group eligibility because of (mark one):

<input type="checkbox"/> Age <input type="checkbox"/> Other (explain)
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Select One

\*Complete next line only if "B", "C" or "D" is checked above.

Name of employee	Employee's Social Security Number
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First Name

**Type of Coverage At Time of Qualifying Event**

FAMILY     SINGLE

	Plan Code	Plan Name	Premium
<input type="checkbox"/> Health Care			\$
<input type="checkbox"/> Dental Care			\$
<input type="checkbox"/> Vision Care			\$

M.I.

I waive **COBRA** coverage - I do not wish to continue my insurance.

Beneficiary Signature	Date Signed
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I wish to enroll in **COBRA**

Beneficiary Signature	Date Signed
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Select One

**NOTE: Please do not send payment; this is not an enrollment form. Upon receipt of this completed and signed eligibility form, an enrollment packet will be sent to you.**

Signature of Agency Benefits Officer	Date signed	Office Phone Number
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Distribution: 1 copy each to:  
 DAS/Benefits Administration      OCSEA Benefits Trust      Agency Benefits Officer      Eligible Beneficiary  
 30 E. Broad St., 28th Floor      390 Worthington Rd., Ste. B  
 Columbus, OH 43215      Westerville, OH 43082-8332

## Instructions

### To Payroll/Personnel Officers

1. Distribute this form to:
  - A. All employees separating from state service, who have any health, dental or vision coverage at the time of separation.
  - B. The dependent(s) of all employees who submit a change form to either drop a dependent or to change from family to single coverage.
2. If you cannot personally give the form to the employee or dependent, please complete all of the information, keep a copy for the employee's personnel file, and mail the form to the last known address. Please include instructions for signing the form and for mailing it directly to the addresses on the bottom of the front side.
3. If the employee or dependent is moving out of state, please check with your plan to determine the availability of out of state providers.

### To Employees and Dependents

1. When the employee or dependent(s) experiences a qualifying event, each person losing coverage has the right to an independent elective choice. If you had family coverage at the time of the qualifying event, and only two people are in your family, it may be less expensive to elect two single coverages instead of continuing the family coverage.
2. If you move out of your health insurance company's service area, please contact Benefits Administration Services at (614) 466-0621 to find out your options to change your coverage.
3. COBRA coverage is for a limited amount of time. Your allocated time is indicated on the front of the form - either 18 months or 36 months (and 29 months if the employee qualifies for Social Security Disability).

However, if you continue health insurance under COBRA, at the end of your COBRA period, you should check with your health plan to determine the availability of a private conversion policy. Not all plans offer a conversion policy. There is **no** conversion or private policy available for dental or vision coverage.
4. You have 60 days from the last day of group insurance membership to elect coverage under COBRA. If you elect coverage under COBRA, you must pay for continuous coverage, back to the first day after you lost group coverage.