Hometown Health
It's your hometown

COBRA CONTINUATION ELECTION FORM

830 Harvard Way • Reno, NV 89502 • (775) 982-3100

EMPLOYEE INFORMATION

NAME (LAST)	(FIRST)	(M.I.)	SOCIAL SECURITY NUMBER	
HOME ADDRESS	**CITY**	**ST**	**ZIP**	**HOME PHONE**

QUALIFYING EVENT (Check One):

- ❑ DEATH OF AN EMPLOYEE
- ❑ EMPLOYEE TERMINATION OF EMPLOYMENT (for reasons other than gross misconduct)
- ❑ EMPLOYEE'S REDUCTION OF HOURS
- ❑ DIVORCE OR LEGAL SEPARATION
- ❑ COVERED EMPLOYEE BECOMES ENTITLED TO MEDICARE BENEFITS - ❑ AGE ❑ DISABILITY ❑ ESRD (End-Stage Renal Disease)

Medicare Eligibility was due to:

- ❑ DEPENDENT CHILD CEASES TO QUALIFY AS A DEPENDENT

DATE OF EVENT:_____ INSURANCE TERM DATE_____

APPLICANT INFORMATION - APPLICANT IS THAT EMPLOYEE, SPOUSE OR CHILD REQUESTING CONTINUATION

*Supply information only if different from above

Applicant Name (Last, First, Middle) _____

Address (Street, City, State, Zip) _____

PROVIDE THE INFORMATION BELOW FOR THOSE PERSONS REQUESTING CONTINUED COVERAGE

NAME (LAST) (FIRST) (M.I.)	BIRTHDAY MO DAY YR	SEX M/F	SOC. SECURITY NO.	PRIMARY CARE PHYSICIAN
Applicant				
Applicant's Spouse				
Dependent Child				
Dependent Child				
Dependent Child				

1. Is any individual(s) listed above currently covered under any other group health plan or Medicare? ❑ Yes ❑ No
   If "YES," check coverage currently covered under: ❑ MEDICARE ❑ MEDICAL ❑ DENTAL ❑ VISION
2. Name(s) of covered individual(s)_____
3. Name and address of insurance company(ies) or other organizations providing benefits:

   Does this other coverage include any exclusion or limitation with respect to any pre-existing conditions? ❑ Yes ❑ No
   If "YES," have the limitations for the pre-existing conditions been satisfied? ❑ Yes ❑ No
4. If covered by Medicare, was eligibility due to: ❑ AGE ❑ DISABILITY ❑ ESRD (End-State Renal Disease)

X_____ X_____

APPLICANT SIGNATURE DATE EMPLOYER SIGNATURE DATE

TO BE COMPLETED BY EMPLOYER:

COBRA EFFECTIVE DATE_____ EMPLOYER NAME_____

GROUP NUMBER_____ EMPLOYER ADDRESS _____

COBRA PREMIUM AMOUNT $_____