COBRA ENROLLMENT FORM • COOK COUNTY EMPLOYEE HEALTH BENEFITS

Cook County Government • Department of Risk Management • Employee Benefits Division

161 N. Clark St., Suite 2400B, Chicago, IL 60601

Phone: 312-603-6385 • Fax: 866-729-3040 • Email: risk.mgmt@cookcountyil.gov

INSTRUCTIONS: Complete and sign this form. Print clearly and make a copy for your records. Return to Employee Benefits Division.

Remember: The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows employees and/or their dependents to continue certain insurance benefits after termination of employment or when a dependent's status changes, resulting in loss of coverage. Coverage for employee/dependent health benefits ends on the last day of the month following the employee termination date**.** Medical, dental and vision plans can be continued for up to 18 months under COBRA or up to 36 for dependents losing eligibility status. Payment of the full monthly cost plus an administrative fee is required. Employees have 60 days to apply for coverage retroactive to benefits termination date by submitting a completed COBRA application to Employee Benefits.

If you no longer need COBRA coverage: Send an email to risk.mgmt@cookcountyil.gov requesting cancellation of coverage.

EMPLOYEE INFORMATION

Social Security #_____ Last Name_____ First Name_____ MI_____

Address_____ Apt. #_____ City/State_____ ZIP Code_____

Home/Cell Phone_____ Work Phone_____ Employee ID #_____

Birth Date_____ Termination Date _____ Email _____

COBRA EFFECTIVE DATE _____

PLAN ELECTION

Check the box by the plan(s) of current enrollment.

Medical	Dental	Vision
☐ Blue Advantage HMO	☐ Dental HMO	☐ Vision Plan
☐ Blue Cross PPO	☐ Dental PPO	

DEPENDENT ENROLLMENT

Last Name First Name

_____

_____

_____

_____

_____

DEPENDENT INFORMATION (Complete only if electing COBRA for dependent only coverage)

Dependent Last Name _____ Dependent First Name _____

Date of Birth _____ Last 4 digits of Social Security Number _____

CERTIFICATION

I hereby certify that the information on this form is complete and accurate to the best of my knowledge. I authorize to receive a monthly premium invoice for payment of my health coverage and agree to pay all applicable out-of-pocket expenses including deductible, coinsurance and copayments. I authorize my doctors, hospital or other provider of medical services to make available to the claims administrator any and all medical records pertaining to myself and my dependents, if any. I also release to the claims administrator any information regarding the medical treatment and benefits for myself and any dependents for the purpose of reviewing medical treatment, validating and determining benefits, as well as for plan administration.

Employee Signature_____ Date Signed_____

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