Post-Employment Benefits and COBRA Information Form

Instructions: Please complete all sections of this form. This document is designed for printing and physical filing. Do not submit this form online.

1. Employee Personal Information

Full Name (Last, First, Middle Initial):

Employee ID or Social Security Number (Last 4 digits):

Mailing Address (Street, Apt/Suite):

City, State, and ZIP Code:

Phone Number:

Personal Email Address:

2. Employment Separation Details

Last Day of Employment (MM/DD/YYYY):

Current Benefits End Date (MM/DD/YYYY):

Reason for Separation (e.g., Voluntary, Involuntary, Retirement):

3. COBRA Coverage Selections

Please indicate your intention to continue coverage under COBRA by typing "Yes", "No", or "N/A" for each plan:

Medical Insurance Continuation:
Yes / No / N/A

Dental Insurance Continuation:
Yes / No / N/A

Vision Insurance Continuation:
Yes / No / N/A

Flexible Spending Account (FSA) Continuation:
Yes / No / N/A

4. Dependent Coverage Information

List any dependents currently covered under your plans who will also be continuing coverage under COBRA:

Dependent 1 Name and Relationship:

Dependent 2 Name and Relationship:

Dependent 3 Name and Relationship:

5. Other Post-Employment Benefits (If Applicable)

Severance Package Benefits Details:

Life Insurance Conversion Option requested? (Type "Yes" or "No"):

6. Acknowledgment and Signature

By signing below, I acknowledge that I have received information regarding my post-employment benefits and COBRA continuation rights. I understand that I have 60 days from the date of my qualifying event or the date of my COBRA notice (whichever is later) to formally elect coverage.

Employee Printed Name:

Date of Signature (MM/DD/YYYY):

Physical Signature Line (For print use only):