A UnitedHealthcare Company

COBRA Election Form

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 • 1-800-444-6222 • www.oxfordhealth.com

Please type or print clearly

LAST NAME	FIRST NAME	MI
STREET ADDRESS		SOCIAL SECURITY NUMBER
CITY	STATE	ZIP
HOME PHONE # ( )	MEMBER ID # (IF APPLICABLE)	

Please complete and sign this form and return it to the above address within 60 days of the date your employer notified you of your right to elect COBRA continuation coverage. Your first month's premium is due within 45 days of our receipt of this election form. After your initial premium payment, Oxford will mail an invoice to you every month in advance for your premium. If subsequent payments are not made within 30 days of the first of each month of coverage, your coverage will be terminated as of the last day for which premium was paid.

CHECK WHICHEVER IS APPLICABLE:

- ❑ I am currently currently enrolled in an Oxford product and wish to elect COBRA continuation coverage.
- ❑ I am electing an Oxford product for the first time (please attach completed member enrollment and physician selection form).

COBRA COVERAGE REQUESTED:

❑ Self only ❑ Self & spouse ❑ Self & 1 child ❑ Self & children ❑ Family

- ❑ Spouse only (please attach completed member enrollment and physician selection form).
- ❑ Dependent(s) only (please attach completed member enrollment and physician selection form).
- ❑ Spouse & dependent(s) only (please attach completed member enrollment and physician selection form).
- ❑ Enclosed is my premium for the first month of coverage in the amount of $ ______ (check made payable to Oxford Health Plans.)

I certify that neither I, nor any of my dependents electing COBRA continuation coverage (if applicable), is currently covered under another group health plan or is entitled to Medicare coverage. I agree to notify Oxford immediately if I or any member of my family electing COBRA coverage becomes covered under another group health plan or becomes entitled to Medicare coverage.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I understand my premiums are due on the first day of each month. If payment is not made within 30 days from the first of the month, I understand I am subject to immediate termination without notice.

I understand that I am not eligible for COBRA if I am, or become:
1. entitled to Medicare;
2. covered under another group health plan that does not limit my coverage due to a pre-existing condition.

I further understand that my eligibility for COBRA will end if the former employer ceases to offer group health coverage.

Signature of COBRA Continuee X ______________________________ Date ______________

Note:
COBRA coverage is provided under the employer's group agreement with Oxford. Coverage is provided by one or more of the following companies: Oxford Health Plans (CT), Inc. , Oxford Health Plans (NJ), Inc. , Oxford Health Plans (NY), Inc. , Oxford Health Insurance, Inc.

TO BE COMPLETED BY EMPLOYER:

Date of Qualifying Event ______________________

Qualifying Event ____

Effective Date of Coverage with Oxford ______________________

Date COBRA Notification Given ______________________

Oxford Group ID Number ______________________

If you elect continuation coverage, your monthly premium will be determined by the type of coverage you select. The current premiums are:
Self only: $ ________ Self & spouse: $ _________ Self & 1 child: $ _______ Self & children: $ _______ Family: $ _______

Employer Name ____

Employer Signature X ______________________________________ Date ______________