DHHS 116C
11/2022

COBRA Health Insurance Information

D08223900360103

- This form MUST be completed by your previous employer or your COBRA insurance company representative.
- Any blanks left on this form may delay the process.
- If you have general questions about this form or the medical programs, please call 1-866-435-7414.

A General Information

Policy Holder Name: _____ SS#: _____

Insurance Plan Name: _____ Policy #:_____

☐Yes ☐No 1. Is the individual eligible to enroll in COBRA coverage?
If no, please explain: _____
If yes, when is/was the policy holder eligible to enroll? (mm/dd/yy) _____

☐Yes ☐No 2. Is the COBRA coverage offered through Avenue H?

☐Yes ☐No 3. Is the individual or any family member enrolled in COBRA coverage?
If yes, name(s) of person(s) enrolled: _____
_____

☐Yes ☐No 4. Has the individual or any family member dropped/changed coverage in the last six months?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy): _____
_____

B COBRA Plan

Questions below refer to the ***COBRA*** plan offered at your company or through Avenue H.

1. When will/did coverage begin? (mm/dd/yy): _____
2. Complete the charts below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

Yearly Health Plan Deductible	
Individual amount	$
Family amount	$

C Policy Holder's Health Plan Choice

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Questions below refer to the plan that the policy holder has selected.
Questions 1-5 refer to the plan selected and only considers the "in-network" benefits.

☐Yes ☐No 1. Is the deductible $2,500 or less per individual?

☐Yes ☐No 2. Is the lifetime maximum benefit $1,000,000 or more?

☐Yes ☐No 3. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

4. What benefits are covered under this plan? (Check all that apply.)
   ☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx

☐Yes ☐No 5. Does the plan cover abortion services?
   If yes, under what circumstances:
   ☐ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
   ☐ Other, please describe: _____

☐Yes ☐No 6. Are the individual's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s):_____
   _____

D Signature

I certify that I am the applicant's former employer or that I am the COBRA insurance company representative. The information on this form is true and correct to the best of my knowledge.

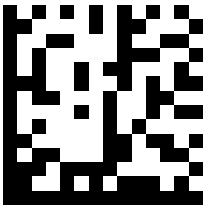
Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

Please return completed form to:

Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Fax: 801-526-9500
Toll-free Fax: 877-313-4717



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