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.

<table>
<thead>
<tr>
<th>Monthly Premium</th>
<th>Yearly Health Plan Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employee’s Portion</td>
</tr>
<tr>
<td>Employee</td>
<td>$</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$</td>
</tr>
<tr>
<td>Employee + child</td>
<td>$</td>
</tr>
<tr>
<td>Family</td>
<td>$</td>
</tr>
</tbody>
</table>

Case #: ____________________
Policy Holder’s Health Plan Choice

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)?

☐ Yes  ☐ No  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):________________________________________________________
   __________________________________________________________________________

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