COBRA ADMINISTRATION FORM

Please complete this form and submit with claims to:

Significa Benefit Services, Inc.
P.O. Box 7777
Lancaster, PA 17604-7777
Fax: (717) 581-8379

COBRA INSURED INFORMATION:

Name: _____ S.S # _____

Address: _____ Telephone: (_____)_____-_____

Previous Employer Name: _____

Spouse's Name: _____ Spouse's Employer: _____

Does your spouse have health coverage through his or her employer? Yes ☐ No ☐

If "Yes", are you covered under your spouse's plan? Yes ☐ No ☐

Effective Date of Coverage: _____/_____/_____

Are you currently employed? Yes ☐ No ☐

If "yes", please list the following:

Name of Employer: _____ Telephone: (___) _____-_____

Address: _____

Are you covered under this employer's health insurance plan? Yes ☐ No ☐

If "yes": Name of Insurance Carrier:_____

Address: _____

Telephone: (_____)_____-_____

Effective Date of Coverage: ____/____/_____

Are you currently covered under Medicare? Yes ☐ No ☐

If "yes": **Part A** – Date_____/_____/_____ **Part B** – Date_____/_____/_____

I understand and agree that the information given is true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____