# 2016 COBRA STATEMENT OF CURRENT COVERAGE
## For Pre-Payment Only
### To be completed by Agency Payroll Personnel

**Name** _____ **SABHRS ID**_____

**Address**_____

_____ **Termination Date:**_____

**Instructions:** Agency payroll personnel will write down the employee's current coverage, as shown in SABHRS, as of the first day of the pay period in which the employee terminates. **This form is only used for terminating employees who are eligible for continuation of benefits under COBRA and wish to prepay benefits payments.** The terminating employee will use this form to make coverage decisions.

You are currently enrolled in the

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Medical Plan Dental Plan

## Members Eligible for Continuation of Coverage

| Type* of Coverage | Name | Relationship** | Birthdate |
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| *Type: M = Medical; D = Dental; V=Vision Hardware | | **Relationship: Sp = Spouse; C = Child; X = Disabled | |

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# COBRA ELECTION FORM
## For Pre-Payment Only
## To be completed by terminating employee

If you are terminating from state employment, and you are eligible to continue coverage through COBRA, you may continue your health care benefits by self-paying the full cost of your benefits payments – see the COBRA rate sheet.

Read through the *Notice of COBRA Rights* for information on your options **before** making your elections**.** If you pre-pay benefits payments for your elections, you will not get a refund if your coverage changes before your pre-payment runs out. Elections made on this form cannot be changed until the next Annual Change period, effective the first day of the next year.

**INSTRUCTIONS:** 1) Have your payroll clerk complete your *Statement of Current Coverage* (above). 2) Circle the names of dependents you will continue to cover after termination and the type of coverage to be continued (medical, dental, and/or vision hardware). 3) Check your method of benefits payment (below). 4) Sign and date this form and return to your agency payroll person.

**METHOD OF PAYMENT AFTER THE PRE-PAYMENT IS EXHAUSTED (choose one):**
____ Monthly Self-Payment to Health Care and Benefits Division by check
____ Electronic Benefits Payment Deduction from Checking or Savings (Attach Authorization Form).

I hereby elect to continue the coverage selected above with the State of Montana Employee Group Benefits Plan. I understand that benefits payments may be adjusted for any future increases or decreases in the cost of the coverage(s) I have selected.

**Signature**_____**Phone:** _____

**Date:**_____

| HEALTH CARE AND BENEFITS DIVISION USE ONLY |
|---|
| **Cobra Coverage effective:** _____ **Total Payment Due:** _____ |
| **Authorized by:** _____ |

Return the completed form to: Health Care and Benefits Division PO Box 200130, Helena, MT 59620-0130. If you have any questions, contact us at (800) 287-8266, (406) 444-7462; TTY (406) 444-1421, or benefitsquestions@mt.gov.