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

Name _____ **SABHRS ID**_____

Address_____

_____ **Current Coverage As Of (MM/YY)** _____

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 _____ Medical Plan	Change my medical plan to: ☐ Traditional ☐ Blue Choice Managed Care ☐ New West Managed Care (available in select areas only) **You can either continue your current medical plan or choose a medical plan with a higher deductible for the remainder of the plan year.**

Members Eligible for Continuation of Coverage

Type* of Coverage	Name	Relationship**	Birthdate
*Type: M = Medical; D = Dental; V=Vision **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). 3) Check the box next to the Medical Plan you wish to elect (above), if changing your current election. 4) Check your method of benefits payment (below). 5) Sign and date this form and return to your agency payroll person.

METHOD OF PAYMENT AFTER THE PRE-PAYMENT IS EXHAUSTED (please choose one):
____ Monthly Self-Payment to Health Care and Benefits Division by check
____Payments from VEBA if eligible
____ Electronic Benefits Payment Deduction from Checking or Savings (Attach Authorization Form). (If you are pre-paying some months of coverage, your preferred method of payment will begin when the pre-payment period ends.)

I hereby elect to continue the coverage selected above with the State of Montana Employee Group Benefits Plan. This coverage will remain in effect unless I change my coverage election, my dependents lose eligibility, or I fail to pay the required benefits payments by the due date. 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:** _____

Distribution: Return the completed **white copy** to: Health Care and Benefits Division PO Box 200130, Helena, MT 59620-0130. The **yellow copy** goes to your agency payroll clerk. Keep the **pink copy** for your records. If you have any questions, call us at (800) 287-8266 or (406) 444-7462; TTY (406) 444-1421 or e-mail us at benefitsquestions@mt.gov.