

COBRA ADMINISTRATION FORM

Please complete this form and submit with claims to:

Significa Benefit Services, Inc.
P.O. Box 7777
Lancaster, PA 17604-7777

COBRA INSURED INFORMATION:

Name: _____ S.S.#: _____ - _____ - _____

Address: _____ Telephone: (____) _____ - _____

Previous Employer Name: _____

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

Does your spouse have health insurance 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: _____

Address: _____ Telephone: (____) _____ - _____

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: _____