

# COBRA ADMINISTRATION FORM

Please complete this form and submit with claims to:

**Significa Benefit Services, Inc.**  
P.O. Box 777  
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 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: \_\_\_\_\_