



# AWC COBRA Enrollment Form

Use this form to **enroll or make changes** in your AWC COBRA insurance.  
**Check all the changes that apply to you and complete all of this form.**

## Change in Coverage:

- New COBRA subscriber  
  Name  
  Address  
  Marital status  
  Drop dependent  
 Add dependent (medical/dental open enrollment or status change only)  
 Other: \_\_\_\_\_

## COBRA Subscriber Information

COBRA subscriber name (last, first, initial)		SSN		Birth date	
Home address			Home phone		Gender
City	State	Zip	County		
<b>Type of insurance requested:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> EAP Are you currently covered on Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No           If yes, Medicare claim number: Date enrolled on Medicare Part A: _____           Date enrolled on Medicare Part B: _____					

**Your Signature is Required** Claims cannot be processed unless this form is signed and dated.

I hereby apply for coverage under the contract between the respective insurance company and my employer and AWC, and I agree with the terms of the contract. I also apply for the same coverage for my spouse and/or my dependent children listed on this application. I certify that my dependents and I meet all the eligibility criteria set forth in the outline of benefits and/or the Contract.

I hereby authorize any healthcare provider or facility to disclose to the company any medical information concerning me or my dependents necessary for the company to exercise its rights and fulfill its obligation under its contract with me. I understand that our medical records may contain information about the diagnosis and treatment of mental health conditions, sexually transmitted diseases and tests for such diseases, and chemical dependency (including alcohol), and I specifically authorize release of such information to the company. I authorize the company to release such information as required by law or as necessary to exercise its rights and fulfill its obligations under its contract with me.

I verify that all of the information specified on this application is accurate and complete. I have also read and understood the application agreement(s) and the release of information provisions stated above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## To be filled out by COBRA Administrator ONLY.

<b>Qualifying Event:</b> <input type="checkbox"/> Left employment <input type="checkbox"/> Reduction in hours <input type="checkbox"/> Divorce <input type="checkbox"/> Death of employee <input type="checkbox"/> Over-age dependent			
Former employer name		COBRA effective date	
If the COBRA subscriber is <u>not</u> the former employee, list name & SSN of former employee.			
Regence/Asuris Plan:	Group Health Plan:	WDS Plan:	Willamette Plan:
VSP Plan:	EAP Plan:	Date form received:	



**COBRA Dependent # \_\_\_\_\_**

Name (last, first, middle initial) SSN Gender Birth date Relationship to insured

Type of insurance requested  Medical  Dental  Vision  EAPIs he/she a full time student?  Yes  No Are you providing majority support for him/her?  Yes  NoDoes he/she live with you?  Yes  No

If no, name of person with whom he/she resides. SSN Home phone

Home address City State Zip

If divorced, do you have custody?  Yes  No Has a court established financial responsibility?  Yes  No

If no, name of person responsible. SSN Home phone

Home address City State Zip

Is dependent covered by any other insurance now or in the past three months?  Yes  No

If yes, name of other insurance company &amp; type (medical, dental, etc.):

Name of insured SSN of insured Group/policy # Termination Date

**COBRA Dependent # \_\_\_\_\_**

Name (last, first, middle initial) SSN Gender Birth date Relationship to insured

Type of insurance requested  Medical  Dental  Vision  EAPIs he/she a full time student?  Yes  No Are you providing majority support for him/her?  Yes  NoDoes he/she live with you?  Yes  No

If no, name of person with whom he/she resides. SSN Home phone

Home address City State Zip

If divorced, do you have custody?  Yes  No Has a court established financial responsibility?  Yes  No

If no, name of person responsible. SSN Home phone

Home address City State Zip

Is dependent covered by any other insurance now or in the past three months?  Yes  No

If yes, name of other insurance company &amp; type (medical, dental, etc.):

Name of insured SSN of insured Group/policy # Termination Date