COBRA Application Form

Name	Social Security No.

I have left pay status for the following reason. (Please check the appropriate box and indicate the effective date below.)

o Approved Sick leave (SLOAC) -- attach approval memo	Effective Date:
o Sick Leave	Effective Date:
o Leave Without Pay	Effective Date:
o Change of Title Title Changed To: _____	Effective Date:
o Change of Agency Name of New Agency: _____	Effective Date:
o Retired	Effective Date:
o Resigned	Effective Date:
o Laid Off	Effective Date:
o Severance	Effective Date:
o Family Medical Leave Act (FMLA). Please attach approval memo.	Effective Date:
o Death of Member	Effective Date:
o Other reason, please specify: _____	Effective Date:

o I do not wish to received benefits from OSA/WF (I have completed the information above).

Signature of Employee	Date
Work Phone No.	Home Phone No.

o I do wish to receive benefits from OSA/WF.

o Enclosed is my COBRA premium o for myself only o For my family o For a family member

o Superimposed Major Medical o for myself o for my family
o Dental/Vision o for myself o for my family
Name of family member:_____
Relationship of family member:_____
My initial payment for three months is enclosed for $_____ for the period __/__/__ through __/__/__. (Follow-up payments should also be in three month payments.)

Also please enclose a copy of your updated COBRA health benefit card received from the City of New York. If you do not have one as yet please enclose a copy of the form you have completed to activate you/or your family as a COBRA recipient with the City of New York Employees Benefit Program.

NOTE: If OSA does not receive a copy of your Health Card, you will not be eligible to purchase COBRA for OSA/WF Dental or Vision Care benefits.

Signature of Employee	Date
Work Phone No.	Home Phone No.