Form 700

Existing COBRA Participant

TO: Via Fax (724) 514-6648
Via E-Mail
linda.rall@hracobra.com or alena.loiselle@hracobra.com or sandra.stankus@hracobra.com
Human Resources America, Inc.
P.O. Box 8
Houston, PA 15342

FROM: _____ ("Client") DATE: _____

_____ Contact name

_____ Contact Telephone

Participant's Name_____Social Security Number_____

Address_____ Date of Birth _____

_____

_____

Original Date of Hire_____ Original Date of Group Coverage_____

Date of Termination_____ Reason for Termination_____

COBRA Acceptance Date _____COBRA paid until _____

COBRA Start Date _____ Date COBRA ends _____

Dependent(s) Name	Date of Birth	Social Security Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Plan names or # _____Tier(Single, Emp. & Spouse, etc.)_____
Dental Plan _____Tier(Single, Emp. & Spouse, etc.)_____
Vision Plan _____Tier(Single, Emp. & Spouse, etc.)_____

Premium _____