Federal COBRA Election Form

Health Net Health Plan of Oregon, Inc.

To elect COBRA continuation coverage, complete this election form and return it **to your employer**. Under federal law, you have 60 days from the date your coverage terminates to decide whether or not you want to elect COBRA continuation.

Employer name:	Group #:
Employee name:	Soc. Sec. #:

Type of qualifying event

Date of qualifying event (enter date): _____

18-month	*29-month*	*36-month*
Employee (and dependent if any) losing coverage due to: ☐ Termination of employment ☐ Reduction in hours	☐ Disabled qualified beneficiary (Name) Attach copy of Notice of Award from SSI	Dependent(s) losing coverage due to: ☐ Divorce or legal separation ☐ Medicare eligible subscriber ☐ Death of subscriber ☐ Loss of dependent-child status

I have read the specific notice of my COBRA options as provided by the employer. I understand I am eligible to self-pay my present Health Net Health Plan of Oregon group health coverage for up to the number of months allowed by federal law. My eligibility for COBRA continuation will end when I become entitled to Medicare or become covered by another group health plan.

☐ **Yes**, I want to continue group medical insurance through COBRA.

1. I understand I must pay any required premium due to the Health Net Group Contract Holder (employer) each month by the date specified by the employer.
2. I wish to elect the COBRA option for:
   ☐ Self only ☐ Self and insured family members ☐ Insured family members
   ☐ Medical only ☐ Dental only ☐ Medical and Dental

Signature: _____ Date: _____

☐ **No**, I am not interested in continuing group medical insurance through COBRA.

Signature: _____ Date: _____

EMPLOYER – Retain original and send a copy of the entire form to Health Net.

Please list all dependents to be covered	*Required*
Qualified dependent name:	Soc. Sec. #:
Qualified dependent name:	Soc. Sec. #:
Qualified dependent name:	Soc. Sec. #:

☐ Another page is attached with required information for additional dependents.

Note: A domestic partner, even an Oregon Registered Domestic Partner or Washington State Registered Domestic Partner, is not eligible for federal COBRA continuation.