DIRECT BILL COBRA / NYSCOB INFORMATION FORM

(This form must accompany each direct bill COBRA application)

Account Name: _____

Account Number: _____

Subscriber ID Number: _____

Benefit Plan Name: _____

Qualifying Event: _____
(For example: Terminated, employment, reduction of hours, divorce, or dependent reached age limit)

COBRA Effective Date: _____ COBRA End Date: _____

I understand that the subscriber's rate will consist of our group rate plus a 2% administrative fee, calculated by using the total premium amount which is to include all riders and endorsements. Enclosed is our subscriber's enrollment application and first month premium.

_____ _____
(Group Administrator Signature) (Date)

_____ _____
(Please Print Administrator Name) (Phone Number)