Surency life and health

Application for Continuation of Group Vision Coverage (COBRA)

With the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans are required to offer employees and dependents losing eligibility the option to continue their coverage. If you wish to extend coverage, you must complete this form and return it to Surency. ***You will then receive a coupon booklet from Surency or payment requests from the group.***

To Be Completed By Applicant (Please Print or Type Legibly)

Name (Last, First, Middle Initial):	Social Security Number:	Date of Birth:	Male: ☐ Female: ☐
Home Street Address:	City:	State: / Zip:	Home Phone:

Please list below all persons who are to be covered.

Last Name (if different)	First Name	Middle Initial	Sex (M/F):	Date of Birth	Indicate if covered by other vision insurance
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Signature of Applicant: _____ **Date:** _____

☐ Yes, I want to continue my vision coverage. ☐ Return form to Human Resources Administrator.

☐ No, I do not want to continue my vision coverage. ☐ Return form to Surency Life & Health.

Please mail form to: Surency Life & Health • COBRA Eligibility • PO Box 789773 • Wichita, KS 67278-9773
Or Fax to: 316.462.3329 (Eligibility Department-COBRA)

To Be Completed By Employer

Subscriber's ID # on previous Surency coverage:	Date:
Group Name & Number:	Date of Qualification:

Reason for Loss of Eligibility (Please check one. NOTE: Applications cannot be processed without this information):

☐ Lay Off ☐ Divorce or Legal Separation ☐ Reduction of Hours ☐ Retired

☐ Termination ☐ Child Reached Age Limit ☐ Death of Employee ☐ Other

Employer Signature:	Title:	Date:

Applicant Eligible for ____ months of coverage. COBRA eligibility to terminate on _____.