COBRA CONTINUATION COVERAGE ELECTION FORM

This form is to be filled out using information from the *COBRA Continuation Coverage Election Notice*.

Please follow the election procedures listed below:

1) Complete, sign and date this COBRA Continuation Coverage Election Form and make a copy for your records.
2) Mail this election form back to: Samaritan Health Plans, P.O. Box M, Corvallis, OR 97339.
3) It is recommended you obtain proof from the Post Office you mailed the election form. Your election is deemed made on the date the election form is sent to the Plan Administrator.
4) The election form may be hand delivered to: Samaritan Health Plans, 2300 NW Walnut Blvd., Corvallis, OR 97330.
5) This election form must be completed and returned or post-marked (if mailed) within 60 days from the notification date on the COBRA Continuation Coverage Election Notice or 60 days from the Plan termination date, whichever is later. No late elections will be accepted.
6) Call the Plan Administrator within 10 days to ensure the election form has been received.
7) Make checks payable to: Samaritan Choice Plans.

If you do not submit a completed election form by the due date referenced above, you will lose your right to elect COBRA Continuation Coverage. If you waive COBRA Continuation Coverage, you may change your mind as long as you furnish a completed election form by the above referenced due date.

Read the important information about your rights included with the election form.

SUBSCRIBER INFORMATION				
LAST NAME FIRST MI		SOCIAL SECURITY NUMBER		SUBSCRIBER ID
STREET ADDRESS	APT #	CITY	STATE	ZIP
DAYTIME PHONE #	ALTERNATE PHONE #		DATE OF BIRTH	GENDER

PERSONS ELECTING COBRA	**COBRA ELECTION**
I (We) elect COBRA Continuation Coverage with Samaritan Health Plans (the Plan) as indicated below:	
I elect to continue my Flexible Spending Account (FSA) contributions as a continuation coverage option. I understand this option is only available if my FSA account was *underspent* at the time of the Qualifying Event. *If unsure whether you qualify for FSA Continuation Coverage, please contact SHP Customer Service.*	FSA contribution ☐

LAST FIRST MI	DATE OF BIRTH	SSN	RELATIONSHIP TO SUBSCRIBER/GENDER	COVERAGE OPTION ELECTED
SUBSCRIBER	Same as above	Same as above	Self/Same as above	None ☐ Medical/Pharmacy ☐ Vision/Dental ☐
				Medical/Pharmacy ☐ Vision/Dental ☐

LAST FIRST MI	DATE OF BIRTH	SSN	RELATIONSHIP TO SUBSCRIBER/GENDER	COVERAGE OPTION ELECTED
				Medical/Pharmacy ☐ Vision/Dental ☐
				Medical/Pharmacy ☐ Vision/Dental ☐
				Medical/Pharmacy ☐ Vision/Dental ☐
				Medical/Pharmacy ☐ Vision/Dental ☐
				Medical/Pharmacy ☐ Vision/Dental ☐

Is anyone applying for COBRA Continuation Coverage currently covered or going to be covered by other group insurance?

☐ No ☐ Yes If yes, please complete the following requested information:

If yes, name(s) of insured: ______________________________

Name of Carrier: ______________________________

Phone Number of Carrier: ____________________ Effective Date: ______________

Subscriber ID #: ____________________ Date of Birth: ______________

Signature: ______________________________ **Today's Date:** ______________

Print Name: ____________________ Relationship to individual(s) listed above: __________

Address: ______________________________ Telephone Number: ______________

City, State, Zip: ____________________ Alternate Telephone Number: ______________

FOR OFFICE USE ONLY:

Samaritan Choice Plans/Pharmacy:	**Vision/Dental:**	**FSA:**
☐ Wellness ☐ Wellness Incentive ☐ High-Deductible	☐ Willamette ☐ Delta	☐
Verified: ☐ Sub Only ☐ Sub/Spouse ☐ Sub/Dep ☐ Family ☐ Dep Only ☐ Spouse Only ☐ Spouse/Dep	**Verified:** ☐ Sub Only ☐ Sub/Spouse ☐ Sub/Dep ☐ Family ☐ Dep Only ☐ Spouse Only ☐ Spouse/Dep	

COBRA Effective Date: ___/___/_____ COBRA Termination Date: ___/___/_____ New Sub ID needed: ☐ Yes

NOTES: