



Extended Health Insurance

COBRA employee enrollment

Deadline to enroll is 60 days from the date of your notification letter.

EMPLOYEE

• FOR BENEFITS USE ONLY •

APPLICANT'S NAME Last	First	MI	Social Security Number (last 4 digits)
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BILLING ADDRESS (Include city, state, zip)	Daytime phone (include area code)	COUNTY
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Present University System of Georgia health insurance contract number (if known)	APPLICANT'S DATE OF BIRTH Mo. Day Year	Date of separation from UGA Mo Day Yr	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(ed) <input type="checkbox"/> Separated	Coverage desired <input type="checkbox"/> Applicant only <input type="checkbox"/> Applicant + one child <input type="checkbox"/> Applicant + spouse <input type="checkbox"/> Family
Date of last payroll deduction for health insurance (if known)	Email address				

Applicant signature

Date signed

• IMPORTANT •

For reimbursement, your healthcare plan may restrict your choice of who may treat you or your family, and, where you or your family may be treated.

University System of Georgia healthcare plan info:
<http://www.usg.edu/employment/benefits/health/>

Health plan choice:
You are not eligible to change health plans unless you meet certain criteria. Please contact HR at 706-542-2222 or benefits@uga.edu for assistance.

Open Access POS
 HSA Open Access POS
 BlueChoice HMO
 Kaiser Permanente HMO

• FOR BENEFITS USE ONLY •

Effective date _____

Premium _____

Term date _____

Bill month _____

Complete & return this form to:
Employee Benefits
Human Resources Bldg.
215 South Jackson Street
Athens, GA 30602-4133

List all eligible individuals you wish to cover.

	Last name	First name	Gender	Birthdate		
				Month	Day	Year
2.			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
		<input type="checkbox"/> SPOUSE				
		Children	Complete if child is over 19			
3.		<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
4.		<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
5.		<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
6.		<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
7.		<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

Are you or your spouse covered under any other group/employer health insurance program?
 Yes No

If yes, complete sections A through C below.

Check here if you are eligible for Medicare:
 Part A Effective date _____
 Part B Effective date _____
Medicare HIC # _____

A. Name of insurance co. (s) & employer
Self _____
Spouse/dependent _____

B. Effective date(s) of policy(ies) & contract number(s)

C. Type of contract Self only Family

HMO ONLY

Information should correspond to the numbers of covered individuals listed above. (#1 is self; #2 is spouse; #3 is a child, etc.)

Primary Care Physician Name	Primary Care Physician ID # (if listed at left)
1	1
2	2
3	3
4	4
5	5
6	6
7	7