

Read the Benefits Workbook for COBRA Participants for more information about benefit plan options, costs and requirements.

COBRA Participant Information						Please print or type.	
Last Name		First Name		M.I.	Social Security Number		
Street Address				Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth - Month/Day/Year	
City		State	Zip	Work Phone		Home Phone	

Reason for Enrollment/Change

Changes during the year to benefit enrollments must be made within 30 days of a qualifying change in family or life status (see options below). No other changes are permitted until the annual Open Enrollment period.

DATE LIFE EVENT OCCURED: _____

<input type="checkbox"/> Open Enrollment (OE)	<input type="checkbox"/> Birth/Adoption of child* (<i>documentation required</i>)
<input type="checkbox"/> Marriage* (<i>documentation required</i>)	<input type="checkbox"/> Child age 26 is no longer eligible for coverage
<input type="checkbox"/> Domestic Partner relationship established* (<i>documentation required</i>)	<input type="checkbox"/> Commencement of dependent's or spouse's/domestic partner's coverage under another plan
<input type="checkbox"/> Divorce* (<i>documentation required</i>)	<input type="checkbox"/> Termination of dependent's or spouse's/domestic partner's coverage under another plan* (<i>documentation required</i>)
<input type="checkbox"/> Domestic Partner relationship terminated* (<i>documentation required</i>)	<input type="checkbox"/> Moving away from the area
<input type="checkbox"/> Death of spouse/domestic partner/dependent* (<i>documentation required</i>)	
<input type="checkbox"/> Other (subject to HR approval): _____	

TO BE COMPLETED BY HUMAN RESOURCES:

DATE BENEFITS ENROLLMENT/CHANGE TO BECOME EFFECTIVE:

On the date of change

1st of month following change

* Documentation required to verify life/status event change within 30 days. Contact Human Resources at 412-268-2047 to learn more about the supporting documentation that must be submitted or completed.

Medical Election	Dental Election	
<p>I elect the following medical carrier:</p> <p><input type="checkbox"/> UPMC</p> <p><input type="checkbox"/> HealthAmerica</p> <p><input type="checkbox"/> Highmark</p> <p><input type="checkbox"/> Waive medical/prescription coverage</p> <p>NOTE: If you elect medical coverage, you must select a prescription option for the same individuals.</p>	<p>I elect the following medical plan:</p> <p><input type="checkbox"/> PPO Option 1 (Highmark/UPMC)</p> <p><input type="checkbox"/> PPO Option 2 (Highmark/UPMC)</p> <p><input type="checkbox"/> PPO Option 3 (Highmark/UPMC)</p> <p><input type="checkbox"/> High Deductible PPO w/HRA (Highmark/UPMC)</p> <p><input type="checkbox"/> HealthAmerica HMO</p> <p><input type="checkbox"/> Comprehensive (Highmark only)</p>	<p>I elect the following dental plan:</p> <p><input type="checkbox"/> Concordia PPO Option 1 (Basic)</p> <p><input type="checkbox"/> Concordia PPO Option 2 (Preferred)</p> <p><input type="checkbox"/> Concordia DHMO</p> <p><input type="checkbox"/> Waive dental coverage</p> <p>I elect the following level of coverage:</p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Family (employee, spouse, children)</p> <p><input type="checkbox"/> Family (employee, DP, children)</p>
<p>I elect the following level of coverage:</p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Individual & Child</p> <p><input type="checkbox"/> Individual & Children</p> <p><input type="checkbox"/> Individual & Spouse</p> <p><input type="checkbox"/> Individual & Domestic Partner</p> <p><input type="checkbox"/> Family (individual, spouse, children)</p> <p><input type="checkbox"/> Family (individual, DP, children)</p>	<h3>Prescription Election</h3> <p>I elect the following prescription drug plan:</p> <p><input type="checkbox"/> Caremark Option A</p> <p><input type="checkbox"/> Caremark Option B</p> <p><input type="checkbox"/> Waive medical/prescription coverage</p>	<h3>Vision Election</h3> <p>I elect the following vision plan:</p> <p><input type="checkbox"/> Davis Vision Option 1</p> <p><input type="checkbox"/> VBA Option 1</p> <p><input type="checkbox"/> Davis Vision Option 2</p> <p><input type="checkbox"/> VBA Option 2</p> <p><input type="checkbox"/> Waive vision coverage</p> <p>I elect the following level of coverage:</p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Family (employee, spouse, children)</p> <p><input type="checkbox"/> Family (employee, DP, children)</p>

Additional Medical Coverage		
Complete if you or any of your dependents are covered by medical insurance in addition to the Carnegie Mellon plan.		
Insurance Company	Group Number	ID Number

Additional information required on reverse side.

Employee & Dependent Information Complete if covering spouse/domestic partner or children. Copy this page if needed for additional dependents.						
COBRA Participant	If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCP			If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCD		
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCP		If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCD		
Dependent 1	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCP		If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCD		
Dependent 2	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCP		If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCD		
Dependent 3	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCP		If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCD		
Dependent 4	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCP		If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCD		
COBRA Participant Signature						
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties. I agree to comply with all provisions and procedures that govern administration of the Benefit Plans for Carnegie Mellon. I understand the university will make the necessary adjustment to my costs based on these changes/elections.						
_____ Signature					_____ Date	
For Benefits Office Use Only						
_____ Signature					_____ Date	

Return to: Human Resources – Benefits Office, 319 SCRG, 5000 Forbes Avenue, Pittsburgh, PA 15213.

Questions? 412-268-2047 or hrhelp@andrew.cmu.edu