SAG-AFTRA HEALTH PLAN

3601 W. Olive Ave., Burbank, CA 91505 • Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830
P (800) 777-4013 • F (818) 953-9880 • www.sagaftraplans.org/health

COBRA Enrollment Form
Loss of Earned Coverage

To enroll in the COBRA program return this form to the SAG-AFTRA Health Plan (Plan) no later than 60 days from the date your coverage ended or the date on your COBRA enrollment offer, whichever is later. COBRA coverage will be extended only when your enrollment is completed and payment is received.

Participant name	Date of birth	Social Security number or health care ID (HCID)	
Address		Phone	Email

Choose one Plan and one rate within that Plan:

Plan I — monthly rates

Individual only ◯ $832
Individual plus one dependent ◯ $1,506
Individual plus two or more dependents ◯ $2,114

Plan II — monthly rates

Individual only ◯ $592
Individual plus one dependent ◯ $1,044
Individual plus two or more dependents ◯ $1,452

List the dependent(s) you wish to enroll under COBRA and complete the signature section.

First and last name	Gender (M/F)	Date of birth (MM/DD/YYYY)	SSN	Relationship: spouse; biological, step, adoptive or foster parent; legal guardian

Important: If you add a new dependent above, the Plan requires a copy of the *recorded* marriage certificate, birth certificate or adoption/guardianship papers (a birth certificate from a hospital for a child younger than one year is acceptable for up to 120 days while you obtain a recorded copy). The Plan must receive your premium and approve all required documents before providing coverage. A new billing statement will be sent to you if a new dependent changes the amount you owe. If you remove a dependent from your coverage due to divorce or death, you must provide the Plan with a copy of the final judgment of divorce (within 60 days) or the recorded death certificate. The Plan does not cover the health expenses of an ex-spouse.

I agree to the terms and conditions of the COBRA program:

Participant signature _____ Date _____