

Application to Continue Benefits--COBRA
South Dakota State Employee Benefit Program
500 East Capitol Avenue Pierre, SD 57501-5070
Phone: 1.877.573.7347, option 2
Fax: 605-773-6840
http://benefits.sd.gov

Name: _____ SSN or Insurance ID: _____
 Last First MI

Mailing Address: _____
 Street City State Zip Code

Date of Birth: ____/____/____ Phone: _____ Email: _____

1) I am: a former employee a participating family member
 (If electing continuation coverage, please complete the Direct Payment Plan form and attach a voided check.)

If you are a participating family member, please list current or former employee information:

Name: _____ Emp. Soc. Sec. No. _____ - _____ - _____

2) I DO elect continuation coverage.
 I DO NOT elect continuation coverage. (Please complete the information above, sign and return this form.)

3) Participant and/or dependent information for each person who will be continuing coverage:

Name	Birth Date	Soc. Sec. No.	Which Plan(s)?

4) I request continuation coverage for the following plans: **(Check all that apply.)**

- | | |
|---|---|
| <input type="checkbox"/> Health Plan | <input type="checkbox"/> Medical Reimbursement Account component of Flex Plan |
| <input type="checkbox"/> \$750 Deductible Plan | <input type="checkbox"/> Dental Plan component of Flex Plan |
| <input type="checkbox"/> \$1250 Deductible Plan | <input type="checkbox"/> Base Plan |
| <input type="checkbox"/> \$1800 Deductible Plan | <input type="checkbox"/> Enhanced Plan |
| | <input type="checkbox"/> Vision Plan component of Flex Plan |

5) Non-tobacco User or Tobacco User?

- | | |
|---|---|
| <input type="checkbox"/> I am not a tobacco user | <input type="checkbox"/> My covered spouse is not a tobacco user |
| <input type="checkbox"/> I am a tobacco user | <input type="checkbox"/> My covered spouse is a tobacco user |

6) Which qualifying event(s) make you eligible for continuation coverage?

- | | |
|---|--|
| <input type="checkbox"/> Employee Termination | <input type="checkbox"/> Divorce or Legal Separation |
| <input type="checkbox"/> Employee Death | <input type="checkbox"/> Receiving Coverage Under Medicare |
| <input type="checkbox"/> Reduction of Employee's Hours | <input type="checkbox"/> Disabled Employee |
| <input type="checkbox"/> Child is Ineligible to be Covered as a Dependent | <input type="checkbox"/> Retired Employee* |
- * Watch for Retiree Enrollment forms coming soon.

I authorize the South Dakota Retirement System (SDRS) to release to the South Dakota Bureau of Human Resources my address, phone number, and/or email on file for the purpose of the Bureau of Human Resources contacting me regarding my health insurance, and/or flexible benefits.

I represent that the foregoing information is, to the best of my knowledge and belief, accurate. I agree that to retain coverage, I (we) must abide by the Plan's provisions.

Applicant Signature
 BHR Form COBRA

Date Signed