

**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"/> \$1800 Deductible Plan | <input type="checkbox"/> Base 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 <b>not</b> a tobacco user | <input type="checkbox"/> My covered spouse is <b>not</b> 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