SEATTLE HOUSING AUTHORITY
2020 COBRA BENEFITS ELECTION FORM

Please Print Clearly

Last Name **First Name** **Gender** **Birth Date** **Phone Number**

Home Address (Street, City, State, Zip) **Social Security Number**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

☐ Retirement/Separation from SHA ☐ Open enrollment Effective Date of Coverage_____
☐ Overage Dependent ☐ Divorce / Termination of Domestic Partner

COBRA Plan Election Option: Select One:
☐ **Medical, Dental and Vision** ☐ **Medical Only** ☐ **Dental and Vision Only**

Medical Plan Selection: (if elected above)

☐ **City of Seattle Preventive Plan** (administered by Aetna)

☐ **City of Seattle Traditional Plan** (administered by Aetna)

☐ **Kaiser Permanente Standard Plan**

☐ **Kaiser Permanente Deductible Plan**

Vision Plan: (if elected above)
☐ Vision Service Basic **OR** ☐ Vision Service Buy-up

Dental Plan Selection: (if elected above)
☐ Delta Dental of Washington ***OR*** ☐ Dental Health Services

Dependent Enrollment: List all eligible dependents to be enrolled. Attach a list for any additional dependents.

PRINTED NAME	SOC. SEC. NO.	BIRTH DATE (M/D/Y)	ENROLL IN Medical	ENROLL IN Dental/Vision
_____ ❑ Spouse ❑ Domestic Partner ❑ Male ❑ Female	_____	_____	❑ Yes ❑ No	❑ Yes ❑ No
_____ **Dependent Child #1** ❑ Male ❑ Female ❑ Son ❑ Daughter ❑ Other (Step-child or Legal Guardianship) ❑ Partner's son ❑ Partner's daughter	_____	_____	❑ Yes ❑ No	❑ Yes ❑ No
_____ **Dependent Child #2** ❑ Male ❑ Female ❑ Son ❑ Daughter ❑ Other (Step-child or Legal Guardianship) ❑ Partner's son ❑ Partner's daughter	_____	_____	❑ Yes ❑ No	❑ Yes ❑ No

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the COBRA election form and descriptive material covering the options provided under the City of Seattle's benefit plans. I authorize the insurance carriers to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I understand that if I fail to make the required COBRA premium payment by the stated deadline, my COBRA coverage may be terminated retroactive back to the last month in which my premium was paid in full.

►**Employee Signature**_____**Date**_____