

# COBRA Request Form

To request COBRA benefits please fill out this form and return to:

**WEBER SCHOOL DISTRICT  
PAYROLL OFFICE  
5320 S Adams Ave Parkway  
Ogden UT 84405**

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## GBS COBRA INPUT SHEET

### EMPLOYEE INFORMATION

|                               |                                 |              |
|-------------------------------|---------------------------------|--------------|
| LAST NAME _____               | FIRST NAME _____                | MIDDLE _____ |
| ADDRESS _____                 | CITY, STATE, ZIP _____          |              |
| SOCIAL SECURITY NUMBER _____  | HIRE DATE _____                 |              |
| PHONE NUMBER _____            | BIRTH DATE _____                |              |
| MALE <input type="checkbox"/> | FEMALE <input type="checkbox"/> |              |
| BENEFIT START DATE _____      |                                 |              |

|   |   |
|---|---|
| EVENT DATE _____  |   |
| <input type="checkbox"/> TERMINATION                      | <input type="checkbox"/> REDUCED HOURS      |
| <input type="checkbox"/> RETIREMENT                       | <input type="checkbox"/> LEAVE OF ABSENCE   |
| <input type="checkbox"/> TERMINATION RETIREMENT MEDICARE  | <input type="checkbox"/> DIVORCE SEPERATION |
| <input type="checkbox"/> DEATH                            | <input type="checkbox"/> LOSS OF COVERAGE   |
| <input type="checkbox"/> INELIGIBLE DEPENDENT             | <input type="checkbox"/> STATE CONTINUATION |
| <input type="checkbox"/> COBRA Premium Employer Subsidize | <input type="checkbox"/> Other: _____       |

|                    |                 |
|--------------------|-----------------|
| MEDICAL PLAN _____ | Single _____    |
|                    | Two Party _____ |
|                    | Family _____    |

|                   |                 |
|-------------------|-----------------|
| DENTAL PLAN _____ | Single _____    |
|                   | Two Party _____ |
|                   | Family _____    |

|                   |                 |
|-------------------|-----------------|
| VISION PLAN _____ | Single _____    |
|                   | Two Party _____ |
|                   | Family _____    |

|                                       |                              |                             |
|---------------------------------------|------------------------------|-----------------------------|
| Flexible Spending Account Participant | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---------------------------------------|------------------------------|-----------------------------|

### DEPENDENTS

|              |                     |                    |
|--------------|---------------------|--------------------|
| SPOUSE _____ | DATE OF BIRTH _____ | BENEFIT DATE _____ |
| CHILD _____  | DATE OF BIRTH _____ | BENEFIT DATE _____ |
| CHILD _____  | DATE OF BIRTH _____ | BENEFIT DATE _____ |
| CHILD _____  | DATE OF BIRTH _____ | BENEFIT DATE _____ |
| CHILD _____  | DATE OF BIRTH _____ | BENEFIT DATE _____ |