Customer Service | P.O. Box 248950 | Oklahoma City, OK 73124-8950
American Public Life Insurance Company | 800-256-8606 | Fax: 877-807-0911

NOTICE OF CONTINUATION OF HEALTH COVERAGE (COBRA)

Employee's Name _____ Social Security #_____

Address _____ Emp. Certificate #_____

City_____ State _____ Zip_____

Employer's Name _____ Group Policy # _____

Address _____

City_____ State _____ Zip_____

Date Employee became eligible for COBRA_____

Home office use only

Eff. Date _____

Exp. Date _____

Rep. _____

Qualifying Event_____

_____

If qualifying event is due to termination, state reason or give details: _____

_____

Person(s) to be covered:

Name	Relationship	Birthdate	Sex	Dependent's Social Security #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If additional space is needed, please use the backside of this form.

Health Premiums (Monthly)

Employee $ _____

Dependents $ _____

Total $ _____

Your election to take the coverage must be signed and received in the office of the Policyholder (former employer) with the first month's premium no later than 30 days after your last day of employment. Future premiums must be in the office of the policyholder within 30 days after the date of your election, and by the same day each month thereafter.

(_____) I hereby elect Continued Coverage and have enclosed one month's premium.

(_____) I decline Continued Coverage.

Signature _____ Date _____
Qualified Employee or Dependent