MESSA
Good health. Good business. Great schools.

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1475 Kendale Blvd., PO Box 2560
East Lansing, MI 48826-2560
Questions? Call 888.888.4167
Fax 517.203.2914
www.messa.org

COBRA Application

Please PRINT clearly or TYPE

MEMBER INFORMATION

SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM-DD-YYYY)	MALE	FEMALE	FIRST NAME	LAST NAME
		☐	☐		

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE	HOME PHONE	E-MAIL
					( )	

DEPENDENT INFORMATION

Please refer to your MESSA Plan Coverage Booklet at *www.messa.org* for complete eligibility guidelines. If necessary, include additional dependent information on a separate sheet of paper and attach to this application.

SPOUSE		SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM-DD-YYYY)	GENDER
				MALE ☐ FEMALE ☐
Dependent	**Relationship to Member**			
				MALE ☐ FEMALE ☐
Dependent	**Relationship to Member**			
				MALE ☐ FEMALE ☐
Dependent	**Relationship to Member**			
				MALE ☐ FEMALE ☐

COVERAGE INFORMATION

IMPORTANT: To designate or change Life Insurance beneficiaries you must submit a ***Beneficiary Designation Form***, available online at ***www.messa.org*** or by calling MESSA at 888.888.4167.

A COBRA CONTINUATION

You may only continue the coverage in which you are currently enrolled.

☐ **HEALTH COVERAGE**
☐ MEMBER ☐ MEMBER & SPOUSE ☐ MEMBER & CHILD ☐ FULL FAMILY $ _____

☐ **DENTAL COVERAGE**
☐ MEMBER ☐ MEMBER & SPOUSE ☐ MEMBER & CHILD ☐ FULL FAMILY $ _____

☐ **VISION COVERAGE**
☐ MEMBER ☐ MEMBER & SPOUSE ☐ MEMBER & CHILD ☐ FULL FAMILY $ _____

FOR EMPLOYER'S USE ONLY

If COBRA coverage is for dependent or spouse, list enrollee SSN: _____

Qualifying Event: _____

COBRA effective date: _____

Comments: _____

EMPLOYER'S INITIALS & DATE and EMPLOYER'S STAMP (Name & Group Number)

TOTAL CONTRIBUTION $ $0.00

SIGNATURE OF APPLICANT	DATE (MM-DD-YYYY)