

# COBRA Participant Information

# Eligibility for Other Coverage

Use this form to notify the Trust that you are eligible for other group health plan coverage (i.e., medical, dental and vision) or Medicare.

## PERSONAL INFORMATION

Name:

Address:

City:

State:

ZIP:

Telephone:

E-mail:

## PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan.  
*If any dependents are also eligible, include their names below.*

Insert date you became eligible:

I am eligible for Medicare.

Insert date you became eligible:

## IMPORTANT

If you fail to notify your plan of becoming eligible for other group health plan coverage (i.e., medical, dental, and vision) or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.

**Eligibility is determined regardless of whether you take or decline the other coverage.**

**However, eligibility for coverage does not include any time spent in a waiting period.**

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature:

Date:

Type or Print Name:

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

Name:

Relationship:

Name:

Relationship:

Name:

Relationship:

Name:

Relationship:

## CCPOA Benefit Trust Fund

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