**Payment Voucher and Eligibility Certification**

**INSTRUCTIONS**: Premium payment is due on the first day of the month of coverage. If payment is not received before the end of the month, coverage will be terminated and there will be no reinstatement. Please complete, sign, and send this Payment Voucher and Eligibility Certification with each premium payment to the address indicated below.

**Qualified Beneficiary Information:** Name and address of person completing this form

Qualified Beneficiary Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MI Last First

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip

Name of Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MI Last First

**Premium and Benefit Information**

Amount Enclosed: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Premium for Month of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Benefit Coverage for: (check one)

\_\_\_\_ Self Only (employee) \_\_\_\_ Spouse Only \_\_\_\_ Dependants Only \_\_\_\_Employee and Spouse

\_\_\_\_ Employee and Child(ren) \_\_\_\_ Employee, Spouse and Child(ren)

**Eligibility Certification**

I hereby certify that I am eligible for COBRA continuation of health coverage and that since the date of my election of COBRA continuation coverage I have NOT:

1. Become covered under any other employer-sponsored group health plan (unless the other plan excludes or limits coverage relating to a pre-existing condition).
2. Become entitled to Medicare.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature Date*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Printed Name*

Please make checks or money orders payable to:

**<COMPANY NAME>**

Attn: COBRA Administrator

**<COMPANY ADDRESS 1>**

**<COMPANY ADDRESS 2>**