Dental: \_\_\_\_\_\_\_\_\_\_\_ Amount Enclosed: Medical: $\_\_\_\_\_\_\_\_\_\_\_ Dental: $\_\_\_\_\_\_\_\_\_\_ Vision: $\_\_\_\_\_\_\_\_\_\_

COBRA Coupons

Month: \_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Amount Enclosed: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount: \_\_\_\_\_\_\_\_\_\_

Payment for Month: (Please Circle) Coupon #: \_\_\_\_

Medical: \_\_\_\_\_\_\_\_\_ Jan Feb March April May June July Aug Sept Oct Nov Dec

Vision: \_\_\_\_\_\_\_\_\_\_\_ Benefit Coverage for: \_\_\_ Self Only \_\_\_ Spouse Only \_\_\_Dependents Only \_\_\_Employee + Spouse \_\_\_Employee + Child(ren) \_\_\_Employee +Family

Check #: \_\_\_\_\_\_\_\_\_\_

**Make checks payable to: <COMPANY NAME>, <COMPANY ADDRESS>**

Month: \_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Amount Enclosed: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount: \_\_\_\_\_\_\_\_\_\_

Payment for Month: (Please Circle) Coupon #: \_\_\_\_

Medical: \_\_\_\_\_\_\_\_\_ Jan Feb March April May June July Aug Sept Oct Nov Dec

Dental: \_\_\_\_\_\_\_\_\_\_\_ Amount Enclosed: Medical: $\_\_\_\_\_\_\_\_\_\_\_ Dental: $\_\_\_\_\_\_\_\_\_\_ Vision: $\_\_\_\_\_\_\_\_\_\_

Vision: \_\_\_\_\_\_\_\_\_\_\_ Benefit Coverage for: \_\_\_ Self Only \_\_\_ Spouse Only \_\_\_Dependents Only \_\_\_Employee + Spouse \_\_\_Employee + Child(ren) \_\_\_Employee +Family

Check #: \_\_\_\_\_\_\_\_\_\_

**Make checks payable to: <COMPANY NAME>, <COMPANY ADDRESS>**

Month: \_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Amount Enclosed: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount: \_\_\_\_\_\_\_\_\_\_

Payment for Month: (Please Circle) Coupon #: \_\_\_\_

Medical: \_\_\_\_\_\_\_\_\_ Jan Feb March April May June July Aug Sept Oct Nov Dec

Dental: \_\_\_\_\_\_\_\_\_\_\_ Amount Enclosed: Medical: $\_\_\_\_\_\_\_\_\_\_\_ Dental: $\_\_\_\_\_\_\_\_\_\_ Vision: $\_\_\_\_\_\_\_\_\_\_

Vision: \_\_\_\_\_\_\_\_\_\_\_ Benefit Coverage for: \_\_\_ Self Only \_\_\_ Spouse Only \_\_\_Dependents Only \_\_\_Employee + Spouse \_\_\_Employee + Child(ren) \_\_\_Employee +Family

Check #: \_\_\_\_\_\_\_\_\_\_

**Make checks payable to: <COMPANY NAME>, <COMPANY ADDRESS>**