CITY OF SAN JOSE C.O.B.R.A.
Consolidated Omnibus Budget Reconciliation Act
(Continuation of Health, Dental Care and Vision Benefits)

COBRA ENROLLMENT FORM

1. Please initial the following:

   ____ I have read the material provided and I wish to continue coverage under COBRA.

2. I qualify for COBRA as a _____ Qualified Dependent
   _____ Former Spouse

   I select the following insurance(s):
   _____ Medical
   _____ Dental
   _____ Vision

3. Please complete the information below for COBRA Enrollment:

4. Covered Retiree's Name _____ SSN _____

5. COBRA Applicant's Name _____ SSN _____

   Applicant's Address _____

   Phone Number _____ Date of Qualifying Event _____

_____ _____
Signature of Applicant Date

RETURN ALL FORMS TO:

City of San José
Office of Retirement Services
1737 N. 1st Street, Suite 600
San José, CA 95112

Fax: 408-392-6732