



American Public Life Insurance Company

A member of the American Fidelity Group

NOTICE OF CONTINUATION OF HEALTH COVERAGE (COBRA)

Employee's Name _____

Soc. Sec. No. _____

Address _____

Emp. Certificate Number _____

City _____ St. _____ Zip _____

Employer's Name _____

Group Policy # _____

Address _____

Do not write in this box/ Home Office Use Only

City _____ St. _____ Zip _____

Date employee became eligible for COBRA _____

Eff. Date. _____

Exp. Date. _____

Rep. _____

Qualifying Event _____

If qualifying event is due to termination, state reason or give details: _____

Person(s) to be covered:

Name	Relationship	Birthdate	Sex	Dependent's Soc. Sec.#
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If additional space is needed, please use the backside of this form.

Health Premiums (Monthly):

Employee \$ _____

Dependents \$ _____

Total \$ _____

Your election to take the coverage must be signed and received in the office of the Policyholder (former employer) with the first month's premium no later than 30 days after your last day of employment. Future premiums must be in the office of the policyholder within 30 days after the date of your election, and by the same day each month thereafter.

(_____) I hereby elect Continued Coverage and have enclosed one month's premium.

(_____) I decline Continued Coverage.

Signature: _____ Date _____

Qualified Employee or Dependent