Iowa Department of Human Services

Employer Verification of COBRA Eligibility

Directions: The policyholder must sign and date this form and then give it to the former employer's human resource representative to complete. Thank you.

Employee Permission to Release Information

I give my former employer permission to share information about my employer health insurance benefits. I will not take legal action against them for sharing this information. This information may be discussed either verbally or in writing. This permission will end thirteen months from the date of my signature. I understand that I have the right to notify my former employer if I want the permission to end at an earlier date.

Name of Policyholder (Please print)	SSN
Signature of Policyholder **X**	Date

The rest of this form is to be completed by the former employer's human resource representative.

1. **List ALL persons covered under the plan and** enter the **effective date** of their Medical and Rx coverage:

Covered Person's Name	Date of Birth	Effective Date Medical and Rx
Start with -		

2. Provide the date the last insurance premium was deducted.
3. Provide the last date of employer sponsored health insurance.
4. Is this policyholder eligible for COBRA benefits? ☐ Yes ☐ No
   If yes, what is the first date of COBRA eligibility?
5. What is the date the first COBRA premium is due?
6. Is the first month's COBRA premiums prorated? ☐ No ☐ Yes, medical amount due $_____
7. If COBRA premiums have already been paid, what are the dates paid and amounts (for the medical and prescription coverage)?
8. Is this a High-Deductible Health Plan (per Section 223(c)(2) of the Internal Revenue Code)? ☐ Yes ☐ No

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Questions or need help? Toll Free 1-888-346-9562 Local (515) 974-3282 Fax (515) 725-0725
HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

470-3037 (Rev. 10/17)

9. Where should COBRA premiums payments be sent?

Name of COBRA administrator: _____

Address: _____

City/State/Zip: _____

Name of COBRA administrator representative: _____

Phone number: _____

If the payment is mailed directly to the COBRA administrator, does a payment coupon need to be included with the payment? ☐ Yes ☐ No

10. Insurance Company Information

Health Insurance Carrier Information	Prescription Carrier Information
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____

11. What are the costs for COBRA for the following for medical and prescription coverage?

Employee only $ _____

Family $ _____

Employee plus children $ _____

Children only $ _____

One dependent only $ _____

Spouse and children $ _____

Employer Information			
Employer Name:			
Name of Employer Representative Completing this Form (please print)			
Signature of Employer Representative			
Date	Phone number	Email address	Employer Fed Tax ID No.

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