

COBRA Medicare Extension Request Form

Please fill out this form in its entirety and send it to us along with a copy of your Medicare card. **Note:** Submitting this form does not guarantee that you will be granted a special Medicare extension for your dependents.

*=Required Fields

Participant Information

*Participant Name (First, MI, Last)

- - -
*Social Security Number

*Email Address

- - -
*Phone Number

*Employer Name or Employer Sponsoring Benefits (Do not abbreviate)

