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COBRA Subsidy Information

Client # _____ Co. Name _____

Note: Payment amount should be 65% of total COBRA premium for assistance eligible individuals.

Employee # _____	Employee Name _____
Social Security # _____ - _____ - _____	Premium Assistance Payment \$ _____

Employee # _____	Employee Name _____
Social Security # _____ - _____ - _____	Premium Assistance Payment \$ _____

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Social Security # _____ - _____ - _____	Premium Assistance Payment \$ _____

Employee # _____	Employee Name _____
Social Security # _____ - _____ - _____	Premium Assistance Payment \$ _____

Employee # _____	Employee Name _____
Social Security # _____ - _____ - _____	Premium Assistance Payment \$ _____

Total Number of Participants _____

Total COBRA Premium Assistance Payments Paid on their Behalf \$ _____

I certify that the information contained above is accurate and I have made these payments on behalf of the employees listed.

Client Signature _____

Date _____