**Retroactive Medical Coverage Election**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EMPLOYEE INFORMATION:** | | | | | | | | |
| Employee Name | | | | Personnel Number | | Telephone Number (optional) | | |
|  | | | |  | |  | | |
| Agency | | | | | Work Location | | | |
|  | | | | |  | | | |
| **INSTRUCTIONS:** | | | | | | | | |
| If you did not have medical coverage during the period of your absence, you may elect to have medical benefits restored during this period. If you elect to have the medical benefits restored, you will be responsible for all applicable costs (employee contributions and buy-ups). If you had coverage through the PEBTF under COBRA , your premiums will be reimbursed and applicable costs (employee contributions and buy-ups) will be deducted from your pay. If you do not respond, your medical coverage will not be reinstated. | | | | | | | | |
| **MEDICAL BENEFITS QUESTIONS:** | | | | | | | | |
| 1. Did you have medical coverage during the following period?  Yes  No | | | | | | | | |
|  | Begin Date | End Date |  | | | | |
|  |  |  |  | | | | |
|  | | | | | | | | |
| 2. Do you want your PEBTF coverage to be reinstated?  Yes  No | | | | | | | | |
| 3. Were you covered under someone else’s medical insurance (example a spouse’s coverage)?  Yes  No | | | | | | | | |
| 4. Were you enrolled in COBRA through the PEBTF?  Yes  No | | | | | | | | |
| **SIGNATURE:** | | | | | | | | |
| Signature | | | | | | | Date | |
|  | | | | | | |  | |
| **Return completed form to**:[NAME], SPF Absence Coordinator, [AGENCY]  [ADDRESS]  [ADDRESS]  **Phone:**        **Fax:**       **Email:** | | | | | | | | |
|  | | | | | | | | |