COBRA Proposal Request Form

Allegiance by Cigna Healthcare

Please submit this completed form to CobraInquire@AskAllegiance.com

Proposal Requested by	**Proposed Effective Date***	
Company Name	**Phone**	**Fax**
Contact Name	**Contact Email**	

**Desired effective date subject to approval by Allegiance COBRA Services*

Company Information

Company Name	**Contact Name**		
Phone	**Fax**	**Email**	
Address	**State of Domicile**		
City	**State**	**Zip**	
# Employees	**# Covered Employees**	**Average Turnover**	**%**
# Current COBRA Participants	**# Locations**	**Approximate # of Qualifying Events in Past Year**	

Broker Information

Broker Name	**Contact Name**
Phone	**Email**

Health Plan Information

# Medical Plans		**Carrier(s)**		**Renewal Date**	
		State situs			
# Dental Plans		**Carrier(s)**		**Renewal Date**	
		State situs			
# Vision Plans		**Carrier(s)**		**Renewal Date**	
		State situs			
Self-funded?	☐ Yes ☐ No	**Open Enrollment Date**			

Services Requested

Initial notices for new enrollees? ☐ Yes ☐ No **State continuation coverage admin.** ☐ Yes ☐ No

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