

Cal-Cobra Enrollment Request Form

Please complete and mail this form to the address listed below so we can begin the enrollment process for your Cal-COBRA benefits.

Mail to: Managed Health Network
Attn: Membership Accounting – Cal-COBRA
1600 Los Gatos Drive, Suite 300
San Rafael, CA 94903

Name (last, first, middle initial): _____

Current Member ID Number (if available): _____

Former Employer: _____

Address: _____

Date of Birth: _____

Dependant Names and Date of Birth: _____

1. _____

2. _____

3. _____

4. _____

5. _____

Signature

Date