

It is necessary to fill  
out this form in order  
to continue your  
COBRA Administration.



**PIEDMONT COMMUNITY HEALTH PLAN**  
*Community Partners for Quality Healthcare*

**RENEWAL COBRA INFORMATION**

PLEASE COMPLETE THIS FORM AND RETURN ALONG WITH YOUR MEDICAL CONTRACT RENEWAL INFORMATION

Company Name: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
COBRA Renewal Date: \_\_\_\_\_

**DENTAL PLAN INFORMATION**

Dental Carrier Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Carrier Contact Name: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

Is Piedmont to contact carrier if a member elects or drops dental COBRA?    Yes     No   
Did rates change at renewal?    Yes     No

*If so, please attach a copy of new rates.*

**VISION PLAN INFORMATION**

Vision Carrier Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Carrier Contact Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

Is Piedmont to contact carrier if a member elects or drops vision COBRA?    Yes     No   
Did rates change at renewal?    Yes     No

*If so, please attach a copy of new rates.*

**FSA INFORMATION**

FSA Administrator Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Contact Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

Is Piedmont to contact administrator if a member elects or drops FSA COBRA?    Yes     No

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Please mail or fax the above information to:

**COBRA ADMINISTRATOR**  
**Piedmont Community Health Plan, 1937 Thomson Drive, Lynchburg, VA 24501**  
**Ph: 434-947-4463 • Fax: 434-845-1850**