LAMAR STATE COLLEGE - PORT ARTHUR	
RECEIPT AND INFORMATION FORM	
NAME:	
EMPLOYEE ID:	
I HEREBY CERTIFY that I have been furnished and that I have read the following information: **CONTINUATION COVERAGE NOTIFICATION** **(COBRA)**	
Copies of the above information will be mailed directly to any spouse and/or dependent not residing with the employee upon request. ☐Yes ☐ No If you marked yes, please provide address(es).	
Employee Signature	Covered Spouse Signature (Required if covered by our health insurance)
Date	Date
If you currently have covered dependents under our group medical plan, please give the following information:	
NAME	DATE OF BIRTH
Spouse:	
Child:	
Child:	
Child:	
Child:	
Child:	
Child:	

Revised 1/2009