NYS Department of Civil Service – Employee Benefits Division

THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009
COBRA CONTINUATION COVERAGE

PLEASE COMPLETE AND RETURN THIS FORM *ONLY* IF YOUR AGENCY HAS LESS THAN 20 EMPLOYEES

Agency Name:_____

Agency Code:_____

How many individuals were employed by your Agency in 2008?_____

Number of full time employees:_____

Number of part time employees:_____ and % of time working:_____

How many employees were terminated, for any reason, since September 1, 2008?_____

Name of Agency Chief Executive Officer:_____

Name of Agency Health Benefits Administrator:_____

Phone Number: _____

Signature of Preparer:_____Date:_____

Please return this completed form to:

Mary B. Frye
Director of Employee Insurance Programs
NYS Department of Civil Service
Employee Benefits Division
Alfred E. Smith Office Building
Albany, NY 12239

Phone: (518) 485-1771 Fax: (518) 473-3292