COBRA CONTINUATION OF COVERAGE ELECTION FORM

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to the Plan Administrator of the employer group health plan under which you are continuing your insurance.

I have read the COBRA Notice of Continuation Right provided to me by my employer. I have decided to do the following:

- ❑ I have been advised of my rights to continuation of coverage and I do not elect to continue my coverage. *If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.*
- ❑ I am a covered employee and wish to continue my coverage under my former employer's group for a maximum of 18 months. I am no longer eligible as an employee because *[check appropriate box]*:
  - ❑ My work hours were reduced
  - ❑ I was laid-off
  - ❑ I was fired
  - ❑ I quit
  - ❑ I am totally disabled (29 month continuation is possible)

  Other (please describe) _____

I understand that I must pay my premium cost for coverage to the plan administrator. My dependents covered at the time I became ineligible will also be covered, unless I notify the plan administrator differently.

I understand that if an insured employee does not wish to continue coverage for himself, I, a covered spouse and/or child of that insured employee, may elect to continue the coverage on my own for a maximum period of 18 months.

- ❑ I am a covered spouse and/or child of a former insured employee, and I elect to continue the coverage on my own under his former employer's group for a maximum of 18 months.
- ❑ I was a dependent of an insured employee covered under a plan providing insurance, but I am no longer eligible for coverage. I wish to continue my coverage. I am no longer eligible as a dependent because *[check appropriate box]*:
  - ❑ My spouse or parent is no longer eligible as an employee.
  - ❑ I am separated or divorced from an employee.
  - ❑ My spouse is no longer eligible as an employee, but is eligible for Medicare.
  - ❑ My spouse or parent is deceased.
  - ❑ I am no longer eligible as a child.

  Other (please describe) _____

I understand that I must pay the cost of my coverage to the plan administrator within 45 days following the date I return this form. Coverage is provided only when the full premium for the applicable period is received. You must pay any premiums after that within 30 days of the date the premium is due. Premium payments must be made to the plan administrator.

Name: _____ Date: _____
Please Print

Address _____ Phone: _____

Group Policy No.: _____ Employer Name: _____

Signature: _____ Last Day Worked: _____

Social Security No.: _____