COBRA/STATE CONTINUATION ELECTION FORM

I wish to continue coverage under the___*employer*___ Employee Benefit Plan. I understand that this election is subject to the Plan. I have read and understand the COBRA Continuation Coverage Notice and the letter that accompanied this election form and both COBRA rights and limitations on those rights.

☐ YES ☐ NO

IF YES, PLEASE ATTACH A NEW APPLICATION

Effective date of continuation coverage: _____

First payment is enclosed: ☐ YES ☐ NO

(If first payment is not enclosed, you may not be able to access health care coverage until payment is received.)

Qualifying Event:

☐ Termination ☐ Death

☐ Reduction in hours ☐ Divorce ☐ Other _____

Type of Insurance Selected:

☐ Health ☐ Dental ☐ Vision

(May not add lines of Insurance until Open Enrollment.)

Type of Coverage Selected:

☐ Individual ☐ Husband/Wife ☐ Parent/Child ☐ Family

(Dependents may not be added until Open Enrollment unless a change in family status occurs.)

_____

Signature Date

_____

Print Name Social Security Number

_____

Signature of Witness

For Employer to complete:

Continuation coverage end date: _____

Bill to Company: ☐ Bill to Qualified Beneficiary: ☐

_____

Billing address

_____

City State Zip