

ELECTION FORM

I have read the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), which was signed into law on April 7, 1986 as Public Law 99-272. My circumstances are as follows:

(Check)

- I have been advised of my rights under the above legislation and I do not elect to continue my coverage.
- I am a former employee and wish to continue my coverage under my employer's group coverage for a maximum of 18 months. My coverage would otherwise terminate because:
- Reduction or work hours
 - Lay-off
 - Discharge
 - Other (describe)

I understand that I am obligated to pay the full cost of my coverage to my employer including the amount normally paid in my behalf by my employer. My dependents will also be covered.

- I am a dependent covered under a plan providing insurance, and I wish to be covered as an insured for a maximum of 36 months because of:
- Separation or divorce
 - Medicare ineligible spouse of child of a Medicare covered worker
 - Dependent child losing coverage because of attaining the limiting age
 - Other (describe)

I understand that I am obligated to pay the full cost of my coverage to my employer including the amount normally paid in my behalf by my employer.

Signed: _____

Name (Print):

Date:

Group Number:

Employee Number:

Employer Name:

Employer Address:

