C O B R A

Cobra Continuation Coverage Election Form

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: ______________________________

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This Election Form must be completed and returned by mail or hand delivery on ______________________________.

If mailed, it must be post-marked no later than ______________________________.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation 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. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date that your group health plan coverage terminated.

READ THE IMPORTANT INFORMATION PROVIDED ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS (included in COBRA Election packet MKT-171)

I (We) elect COBRA continuation coverage in the following group health plans (the plan) as indicated below:

Type of plans (please check): ☐ Health ☐ Dental

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
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LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

Type of coverage elected (please check one only):

☐ I (We) elect to continue family coverage under the plan
☐ I (We) elect to continue single coverage under the plan
☐ I decline/waive my right to COBRA continuation coverage under the plan

SIGNATURE PRINT NAME DATE

PRINT ADDRESS TELEPHONE NUMBER

RELATIONSHIP TO EMPLOYEE