C O B R A

COBRA Continuation Coverage Election Letter

Date of Notice: _____
MM/DD/YYYY

To: _____
NAME OF EMPLOYEE, SPOUSE, DEPENDENT CHILDREN, AS APPROPRIATE

Address:_____
ADDRESS TO WHICH NOTICE IS BEING SENT

This notice contains important information about your right to continue your health care coverage with your group health plan(s). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions to complete the Election Form (MKT-365) and submit it to the Plan Administrator at the address below. This Election Form should be included in your COBRA Election Packet (MKT-171).

If you do not elect COBRA continuation coverage, your coverage under the plan will end on _____.
MM/DD/YYYY

Please check the reason below:

☐ End of employment ☐ Reduction in hours of employment ☐ Death of employee
☐ Divorce ☐ Enrollment in Medicare ☐ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the plan for up to _____ months.

Please check the appropriate box or boxes below and give the name:

☐ Covered employee or covered former employee _____

☐ Covered spouse or covered former spouse _____

☐ Dependent child(ren) covered under the plan on the day before the event that caused the loss of coverage _____

_____

☐ Child who is losing coverage under the plan because he or she is no longer a dependent under the plan _____

_____

If any of the persons listed above do not reside at the address to which this notice was sent, please notify the Plan Administrator of the new address for these persons so that we may give them a copy of this notice.

If elected, COBRA continuation coverage will begin on _____ and can last until _____.
DATE DATE

You may elect either family coverage or single coverage for COBRA continuation coverage.

COBRA continuation coverage cost — Family: _____ Single: _____
Your cost for COBRA coverage may change over time, as the cost of benefits under the plan changes. You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in "Important Information about your COBRA Conntinuation Coverage Rights" (MKT-54).

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact:

Plan Administrator:

Name/Position:

Address: Phone Number: