

# COBRA

## 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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. 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.

### 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
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		

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 \_\_\_\_\_