



health plans

COBRA CONTINUATION ELECTION FORM

Date: _____ Group Number: _____

To: _____ Employee: _____

Company Name: _____ SS#: _____

Please complete this form and return it to the employer within 60 days after the later of (a) the date coverage terminates after the qualifying event, or (b) the date the qualified beneficiary is sent this notice.

- 1. Coverage is to be continued: Yes No
- 2. If "yes" is checked, please complete the items below. **If "no" is checked, please sign, date, and return this form.**
- 3. Coverage is to be continued for:

- Myself only Myself and the dependent(s)* listed below
- Dependent(s)* only, listed below

*Dependent(s)	Social Security #	Relationship
Name: _____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please sign warranting that each dependent has no other unlimited or unrestricted group coverage:

X _____

4. Description of qualifying event: _____

5. Qualified person: _____

First Name	Last Name	Birthdate (mm/dd/yy)	Telephone No.
_____	_____	_____	_____
Address	City	State	Zip
_____	_____	_____	_____

X _____
 Signature of Qualified Person Date Signed

EMPLOYER USE ONLY

First premium due date: _____ (Date COBRA coverage begins)	Date of qualifying event: _____ (Exact date of termination, birthdate, etc.)
Date COBRA ends: _____	<input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos