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 or 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: