COBRA CONTINUATION OF COVERAGE ELECTION FORM

Employer _____ Group Policy#_____

Persons Electing to Continue Coverage

	Date of Birth	SSN
Employee _____	_____	_____
Spouse or Former Spouse_____	_____	_____
Child(ren) _____	_____	_____
_____	_____	_____

Address_____

Qualifying Event (Check all that apply)

Termination or reduction of hours worked _____

Employees Entitlement to Medicare _____

Dependent No Longer Eligible _____

Divorce _____ Employee's Death _____

EMPLOYER: This is to inform you that I wish to continue my: Dental _____, Vision _____, and/or Unreimbursed Medical _____ coverage(s). I have enclosed my monthly premium or will forward the premium to you within 45 days. I understand that I must pay such premiums on a monthly basis by (date) _____, or my coverage(s) will be terminated. I also understand that I am entitled to a grace period of at least 30 days.

I understand that I am not eligible for continuation of coverage if I am covered under any other group health plan or eligible for medicare, whether by virtue of my employment or my spouse's. My eligibility for COBRA coverage will terminate on the date I am covered by any other group plan or become eligible for Medicare. If the other group plan I am covered under does not cover a preexisting condition that applies to me or my dependents, I understand that I may continue my coverage to cover that condition only.*

Are you covered by any other group health plan? Yes _____ No _____

*If yes, do you have a preexisting condition? _____

Signature of Employee _____ Date _____

Signature of Spouse or Former Spouse _____ Date _____

Signature of Child Over 18 _____ Date _____

_____ Date _____

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