COBRA CONTINUATION COVERAGE ELECTION FORM

(Return This Portion to Plan Administrator)

The following Qualified Beneficiary(ies) hereby elect COBRA continuation coverage:

To be completed by Qualified Beneficiary(ies)

NAME OF QUALIFIED BENEFICIARY	DATE OF BIRTH	MEDICAL PLAN	DENTAL PLAN	VISION PLAN

To be completed by Plan Administrator

PREMIUMS					
MEDICAL	SINGLE	$	MEDICAL	EMPLOYEE	$
				EMPLOYEE + 1	$
	FAMILY	$		EMPLOYEE + 2	$
				EMPLOYEE + 3	$
DENTAL	SINGLE	$	DENTAL	EMPLOYEE	$
				EMPLOYEE + 1	$
	FAMILY	$		EMPLOYEE + 2	$
				EMPLOYEE + 3	$
VISION	SINGLE	$	VISION	EMPLOYEE	$
				EMPLOYEE + 1	$
	FAMILY	$		EMPLOYEE + 2	$
				EMPLOYEE + 3	$

Send this form to _____
Plan Administrator at: _____
_____

To Be Completed By Qualified Beneficiary(ies)

I have read and understand this form and my COBRA election rights. I realize that if I elect continuation coverage and fail to pay the required premium on time, this coverage will terminate. I agree to notify the Plan Administrator if I, or any covered family member, becomes entitled to Medicare or covered under another group health plan.

Signature _____
Please print your name _____
Date _____
Address _____
Telephone _____

For internal use only
Received by Plan Administrator (initials) ____
Date_____

10/04