

COBRA CONTINUATION WAIVER OF COVERAGE FORM

Date: _____

_____ Mailed
_____ Hand Delivered

QUALIFIED BENEFICIARY INFORMATION

First Name M.I. Last Name Social Security # (or other identifier)

Home Address City State Zipcode

Marital Status # of Dependent Children

Policy Number

ENTITLEMENT TO COBRA COVERAGE

Your health care coverage under your group health plan will cease on _____ (date) because of the following:

_____ Termination of employment
_____ Reduction in hours of employment

According to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), this is a qualifying event that may entitle you (and your spouse and dependent children, if any) to elect to continue coverage under the plan for up to 18 months from the date of your qualifying event.

WAIVER OF COBRA COVERAGE

You may also be entitled to a different level of benefits under the company's alternative coverage, which may be explained in a separate notice. This notice constitutes your decision to waive your COBRA rights in favor of the alternative coverage. Please complete the form below to make this waiver effective.

WAIVER OF COVERAGE

I have read these explanations and understand the rights that apply under COBRA coverage and the alternative coverage. I hereby elect to be covered under the company's alternative coverage and waive continuation coverage under COBRA. I understand that in making this election, group health coverage will terminate on _____ or, if earlier, the date of the termination of employment or failure to pay the premium on time. I also understand that once this alternative coverage ends, I will not have any continuation coverage rights under COBRA. I understand that my spouse and/or dependent children may have additional COBRA rights if I die, become entitled to Medicare, incur a divorce or legal separation or have a dependent who ceases to be a dependent under the plan.

Print Name

Signature

Relationship

Date

This waiver is effective on _____ . It may be revoked in writing at any time before that date.

For internal use only

Received by Plan Administrator (initials) _____

Date _____